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Reconnection Group for Individuals Who Have Experienced Interpersonal Trauma: An Explanatory Case Study

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Reconnection Group for Individuals Who Have Experienced Interpersonal Trauma: An Explanatory Case Study

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by

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Abstract

Interpersonal traumas are becoming more common to the general public and the need for services to assist the mental and emotional well-being of survivors is increasing. However, due to the complicated impacts of trauma on the mind, body, and spirit there can be a challenge in finding effective treatment options that are long lasting for trauma symptoms. The purpose of this study was to understand the elements of a trauma group treatment (Reconnection group) modality that utilizes psychodrama as the primary treatment option and incorporates mindfulness and yoga as adjunctive treatments with individuals who have experienced interpersonal trauma. Findings suggest that the challenging nature of the group therapy process is needed to cultivate interpersonal and intrapersonal development in participants as well as participants needing to gain skills that help them in their everyday life to combat trauma symptoms. It is the hope that the findings can impact future interpersonal trauma group treatment options as well as provide insight into future quantitative areas to measure with Reconnection group participants.

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Dedication

This dissertation is dedicated to all the first generation college students out there; you can do it even if at times it seems impossible. To my brothers I hope my accomplishments show you that you can achieve whatever goals you have with hard work, passion, persistence, and dedication so go give your all to whatever you want to achieve.

To my gram, who raised me to be resilient and strong. To my mother whose short life gave me passion to help others and last but not least to all interpersonal trauma survivors. You are not broken or defined by your trauma experiences and I hope one day you genuinely believe and feel that.

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Chapter One: Introduction and Overview

Background

Posttraumatic Stress Disorder (PTSD) as a diagnosis was not created until 1982 with opposition, even from the Departments of Veterans Affairs (van der Kolk & Najavits, 2013). Trauma was first viewed as a body based disorder with the body as an organism reliving and reancting the threat so much of the initial research was focused on the biological system (van der Kolk & Najavits, 2013). Historically PTSD was only acknowledged in soldiers; treatment was very limited to giving soldiers a few days rest before returning to the war (Friedman, 2013). Other treatments for veterans focused on daily activities with the goal of returning veterans to productive civilian lives and in Europe hydrotherapy (being emerged into water) and electrotherapy (electrical currents being sent to the brain through wires and electrodes) were utilized as treatment options along with hypnosis (Friedman, 2013). Currently the most utilized treatment options for PTSD are Cognitive Behavior Therapy (CBT), which focuses on behavioral activation, changing unhealthy cognitions, and emotion regulation skills (Hobfoll, Blais, Stevens, & Walt, 2016) paired with medication. CBT approaches in the form of Prolonged Exposure (PE), in which clients are prompted to relive their trauma by telling about it in vivid descriptions during a therapy session (Rosaura Polak, Witteveen, Denys & Olff, 2015). Cognitive Processing Therapy (CPT), where clients provide a written account of their trauma while the therapist uses cognitive therapy in session (Walter, Dickstein, Barnes, & Chard, 2014). PE and CPT interventions are used most frequently in trauma cases.

Traditionally trauma has been treated through talk therapy methods such as CBT, which has improved some symptoms of PTSD but has not been able to fully remediate PTSD symptoms (Ogden, Pain, & Fisher, 2006). Traditional talk therapy relies on verbal expression as

the entry point of therapy allowing for only the explicit and verbally accessible elements of trauma (Ogden, Pain, & Fisher, 2006). Persistent avoidance of stimuli associated with the trauma is part of the diagnostic criteria for PTSD and most clients will avoid conversation about their trauma or dissociate from it when discussing the trauma in detail keeping the focus on the facts of their trauma instead of their own individualized experience. This lack of sharing experiences then continues the cycle of PTSD symptoms.

Trauma work can be done in individual or group therapy both typically focusing on talk therapy methods of CBT in the forms of PE and CPT. Many of the current treatment models for trauma groups follow Herman's (1992) stage model where the focus of the group is on one of the three stages of trauma recovery; a. safety and stabilization, b. remembrance and mourning, c. reconnection and integration. In the stage model for trauma treatment all group members must be at the same stage of recovery to participate in treatment (Mendelsohn et al., 2011). In the stage model format each group member will get an assigned day to complete an exposure intervention with the group observing and supporting in this process. Typical trauma groups do not allow mixed genders in the same group or allow differing traumatic experiences to participate in the same group so that the group has cohesion over similarly shared experiences. Obviously the traditional method for trauma groups being very specific with the trauma recovery stage, gender, and type of trauma limits who can access the trauma group and also does not serve as many trauma survivors as it may be able to without such constraints.

Statement of the Problem

There is an ongoing epidemic of traumatic experiences in the world, The World Health Organization conducted a cross national analysis of more than 100,000 responders over the age of 18 across 21 countries reporting the prevalence of interpersonal trauma to be 18.8 % for both

men and women (Stein et al., 2010). Out of the individuals exposed to a traumatic event one in 12 will develop PTSD and over a third of the individuals diagnosed with PTSD will not fully recover from symptoms of PTSD (Kessler, Sonnega, Bromet, Hughes, Nelson, 1995). With the exposure and experience rates of interpersonal trauma there is a greater need to provide varied treatment options to cater to individual needs. Despite ongoing counseling interventions designed for trauma there is still not an intervention that addresses the psychological and physiological effects of PTSD. This has impacted interpersonal violence survivors because current treatment options just address psychological effects of PTSD symptoms leaving survivors feeling dissociated and untrusting towards their bodies. A possible cause of this problem may be there is not enough research investigating ways to incorporate both psychological and physiological treatment options even though organizations such as the Institute of Medicine (IOM) are calling for more research on complementary and alternative approaches to the treatment of post-traumatic stress symptoms (IOM, 2012). A study, which investigates integrating mindfulness, psychodrama, and yoga into the counseling treatment of interpersonal violence survivors in a qualitative study format to determine the effects of incorporating psychological and physiological interventions with interpersonal violence survivors could add to the literature and assist in shaping future interventions to fully assist client's in recovering from PTSD symptoms.

Significance of the Study

Exposure to a traumatic event is becoming more commonplace in society and a majority of individuals may experience or witness a traumatic event in their lifetime. The current study aims to extend the literature on the effectiveness of yoga and mindfulness as an adjunctive treatment for individuals who have experienced an interpersonal trauma. As well as extending the literature on utilizing psychodrama as a primary treatment option with interpersonal trauma

survivors. Recent research is showing a trend focusing on innovative techniques that are holistic incorporating the body and mind in the treatment of trauma. Such as van der Kolk's book *The Body Keeps the Score: Brain, Mind, and Body in the Healing of Trauma* (2014) focuses on how trauma impacts the body and brain; exploring innovative treatments including neurofeedback, meditation, sports, yoga, and drama that engages the mind and body in recovery from trauma. Additional treatment options will better equip clinicians since there is not one treatment option that will be a good fit for every interpersonal trauma survivor.

Purpose of the Study

The purpose of this qualitative explanatory case study is to understand the elements of a trauma group treatment modality that utilizes psychodrama as the primary treatment option and incorporates mindfulness and yoga as adjunctive treatments with individuals who have experienced interpersonal trauma that attend a public university in the Mid-South of the United States. Of specific interest is the physiological and psychological impact that this treatment modality will have on survivors of interpersonal trauma.

Research Questions

Through my research the following research questions will be explored:

1. How do interpersonal violence survivors and group facilitators describe the process and elements of a group therapy modality that incorporates psychological and physiological approaches?
    a. How do interpersonal violence survivors perceive a group therapy modality that incorporates psychological and physiological approaches?
    b. How do facilitators perceive a group therapy modality that incorporates psychological and physiological approaches?

Definition of Terms

1. Bottom Up Trauma Theory: Trauma approach focusing on addressing trauma at the brainstem to the more complex area of the brain (cortical areas).
2. Clinician: A trained mental health professional providing counseling services such as individual, group, and family therapy.
3. Group Therapy: Group therapy is a form of therapy where a small group of selected individuals meet regularly with a therapist.
4. Interpersonal trauma: Interpersonal trauma can be defined as all traumatic events where the source of trauma is another human being (Widera-Wysoczanska & Kuczynska, 2010). Examples of interpersonal trauma are rape, sexual abuse, mutilation, battery, and assault.
5. Mindfulness: Mindfulness is defined as a state of keen awareness of physical and mental sensations as they occur through the practice of focusing attention to ourselves without judgment (Follette, Palm & Pearson, 2006).
6. Posttraumatic Stress Disorder: Posttraumatic stress disorder (PTSD) can be defined as symptom development after exposure to one or more traumatic events (APA, 2013). Symptom development includes intrusion of memories, persistent avoidance of stimuli associated with the trauma, negative adjustment with thoughts and mood, and persistent physiological arousal and reactivity (APA, 2013).
7. Psychodrama: Psychodrama is an experiential form of therapy where participants enact or reenact situations that are emotionally significant for them by being in the role of the protagonist while other group members are auxiliaries playing roles in the protagonist's scene.

8. Reconnection Group: Title of the trauma focused group being researched that utilizes psychodrama as the primary treatment option and incorporates mindfulness and yoga as adjunctive treatments with individuals who have experienced interpersonal trauma.
9. Top Down Trauma Theory: Trauma approach that works from the top-down, addressing trauma in the cortical areas of the brain before addressing trauma in less complex regions of the brain (brainstem).
10. Yoga: Yoga is the act of practicing mindfulness through the use of physical postures as well as breath to integrate the body, mind and spirit so that emotion, action and intelligence are able to be in balance.

The following definitions are provided to ensure uniformity and understanding of these terms throughout the study. I developed all definitions not accompanied by a citation.

Assumptions

It is assumed that group participants will be truthful and forthcoming about their interpersonal trauma experiences, as well as their own individualized experience participating in group therapy that incorporates psychological and physiological interventions. These assumptions are made based on the fact that participants will review the informed consent with me prior to the interview starting. I outlined how their confidentiality and anonymity will be kept throughout and after the study.

Limitations

During the fall semester it is more challenging to get participants for the group due to counseling services numbers being lower towards the beginning of the semester until students become aware of what services are offered on campus. Since the group and research will be conducted on a college campus there are inherent stressors that students handle relating to their

college experience such as exams, assignments, extracurricular activities, and part/full time jobs that at times effect participant's attendance to group. I am also a co-facilitator of the group, which may impact truthfulness in responding to interview questions.

Delimitation

The group is not marketed or advertised on the university campus to limit participants to those seeking out services at the counseling center due to their level of motivation and desire to be engaged in treatment. Explanatory case study qualitative methods were chosen for this study so that I could narrow down themes for future quantitative studies with the group. Also conducting the research at one college counseling center in the Mid-South was chosen out of access to this center and convenience. These limitations will be considered when examining themes found in the research so that they do not affect the outcome of the study.

Summary

This chapter has provided a brief overview of the background for the study, statement of the problem, purpose of the study, significance of the study, research question, definition of commonly used terms, assumptions, limitations, and delimitations. Focusing on detailing the rationale behind choosing an explanatory case study over other method options.

Chapter two will provide a review of current literature that is relevant to the research study. The description detailing explanatory case study research including how data will be collected and analyzed will be presented in Chapter three.

Chapter Two: Literature Review

Overview

This chapter reviews relevant literature from experts in the field that provides background to the current investigation. Including an introduction to interpersonal trauma describing how it is defined, symptoms, relevant research as well as the need for further treatment options for trauma. Group therapy as a treatment option is addressed as well as its use with trauma survivors, how it has typically been formatted, the benefits and the future needs of trauma focused groups. Followed by literature discussing mindfulness, psychodrama, and yoga as therapy treatment options for trauma survivors.

Interpersonal Trauma

The World Health Organization conducted a cross national analysis of more than 100,000 responders over the age of 18 across 21 countries reporting the prevalence of interpersonal trauma to be 18.8 % for both men and women (Stein et al., 2010). Interpersonal trauma can be defined as all traumatic events where the source is another human being (Widera-Wysoczanska & Kuczynska, 2010). As described by Widera-Wysoczanska and Kuczynska (2010) many researchers will specify interpersonal trauma further and identify the perpetrator as a close person to the victim who has a desire to hurt the victim or has their own goals and agenda that disregards any harm to others. Examples of interpersonal trauma are rape, sexual abuse, mutilation, battery, and assault. Other definitions of trauma exist such as Saporta and van der Kolk (1992) defined potential trauma events as certain or threatened serious injury or death and experienced trauma as disrupted attachment, incomprehension, inescapability, and physiological responses.

Individuals who have experienced an interpersonal trauma are at a higher risk of experiencing additional interpersonal traumas (Telles, Singh, & Balkrishna, 2012). Individuals who have experienced a childhood interpersonal trauma will be more likely to encounter another interpersonal trauma in adulthood (Telles, Singh, & Balkrishna, 2012). Another correlation that has been found is that as the number of traumatic experiences increases so does the posttraumatic stress symptoms and other mental health symptoms (Griffin et al., 2011). Van der Kolk and Fisler (1995) compared first experienced traumatic events in children and adults, and found that when experienced in childhood there is severe biological dysregulation compared to adults but both groups had fragmented memories of the traumatic experience.

Researchers have found that in children and adults who have experienced interpersonal trauma in childhood have higher and more severe daily functioning and mental health problems with more complex symptoms that cause severe impairment (Greeson et al., 2011). Ford, Elhai, Connor and Frueh (2010) found that children who have experienced multiple interpersonal traumas tend to have several clinical diagnoses with worse overall treatment outcomes. Individual reactions to trauma may include difficulty with impulse regulation, somatization, affect, self-perception, attention, systems of meaning, attachment, and interpersonal relationships (van der Kolk, Roth, Pelcovitz, Sunday, & Spinazzola, 2005). It is common for trauma survivors to lose their connection to their own bodily sensations (Lee, Zaharlick, & Akers, 2011). Research has found that trauma interrupts normal physiological responses, which creates post-traumatic stress disorder (PTSD), dissociation, and other trauma related symptoms (van der Kolk, 2006). Individuals are unique and their response to experiencing an interpersonal trauma can vary from symptoms of depression, anxiety or PTSD (Breslau, Davis, Andreski, & Peterson, 1991).

When a traumatic memory is triggered either by internal or external cues this can make an individual feel as if the trauma is reoccurring in the present. When re-experiencing trauma individuals will use the same defense mechanism that were used, such as fight, flight or freeze responses (Langmuir, Kirsh, & Classen, 2012). Noises, smells, sounds, memories, etc. can trigger a survivor to re-experience the trauma and it can happen throughout a survivor's day causing an interruption in daily functioning that they cannot cope with; impacting their sense of self, relationships, and their view of the world (Langmuir, Kirsh, & Classen, 2012). Remnants of interpersonal trauma can be found in the long term effects it has on survivors, which are hyperarousal (heightened anxiety and altered arousal response), fear response (not being able to decipher a safe stimuli versus unsafe since everything is perceived as unsafe), loss of trust, hope, social avoidance, and lack of interest in preparing for the future (van der Kolk et al., 1996). Trauma survivors will actively avoid situations, emotions, and thoughts associated with their trauma to avoid the negative involuntary reactions (Follette, Palm & Pearson, 2006). The avoidance increases suppression by survivors of trauma leading to dissociation and emotional numbing from stimuli (Follette, Palm & Pearson, 2006). The avoidance and suppression survivors of trauma use can also lead to increased attachment to the trauma causing further suffering (Follette, Palm & Pearson, 2006). The reactions listed can therefore lead to long-term, ongoing psychiatric and medical care that can last a lifetime (Felitti et al., 1998).

Although previous research has found that immediate crisis intervention may reduce risks of disorders occurring after a trauma experience, a limitation is that it is unknown if it is truly the interventions themselves or personality traits and resiliency in the individual (Widera-Wysoczanska & Kuczynska, 2010). Research does however support that having social support protects one from being overwhelmed by stress and trauma (van der Kolk, 2006).

Emerson, Sharma, Chaudhry, and Turner (2009) describe the Trauma Center Yoga Program being built on the idea that trauma affects the whole individual including body, mind, and spirit, working on the belief that all three of these areas must be focused on in trauma treatment programs. Experiencing a traumatic event can sever interpersonal connection through feelings of grief, guilt, and/or shame (Keenan, Lumley, & Schneider, 2014). It is common for a trauma survivor to experience self-blame for the trauma, which can hinder the trauma recovery process. Trauma typically makes individuals feel alienated from others. One way to bring back that connection to others is to treat interpersonal trauma in a group format that can create a sense of community over similar experiences and feelings (Emerson, Sharma, Chaudhry, & Turner, 2009). Feeling safe with others and creating safe connections help bring satisfaction and meaning back to lives (van der Kolk, 2006). Keenan, Lumley, and Schneider (2014) describe a critical element of trauma treatment as being able to tell one's story in the process of healing trauma.

According to a meta-analysis by Bradley, Greene, Russ, Dutra, and Westen (2005) they found that 45% of therapy clients with symptoms of PTSD have significant symptoms even after treatment and two-thirds of those who did respond to treatment have a relapse of symptoms within six months. The evidence shows that trauma is resistant to treatment so there is a great need to explore interventions for trauma survivors (Emerson, Sharma, Chaudhry, & Turner, 2009). Organizations such as the Institute of Medicine (IOM) see the need and are calling for more research on complementary and alternative approaches to the treatment of post-traumatic stress symptoms (IOM, 2012).

Posttraumatic Stress Disorder (PTSD)

PTSD can be defined by the DSM-V as symptom development after exposure to one or more traumatic events (APA, 2013). Symptom development includes intrusion of memories,

persistent avoidance of stimuli associated with the trauma, negative adjustment with thoughts and mood, and persistent physiological arousal and reactivity (APA, 2013). PTSD is one of the most common psychiatric disorders with a lifetime prevalence of 7.8% (van der Kolk et al., 2005). The highest rates of PTSD diagnosis are found among survivors of military combat and captivity, rape, and genocide (APA, 2013).

The way a body processes stimuli can be broken down into two categories the high road and the low road (LeDoux, 1996). The low road processes stimuli quickly but less accurately with the goal of protecting the individual sending information from the thalamus to the amygdala in the brain (LeDoux, 1996). On the high road information is sent from the thalamus to the sensory cortex, then to the hippocampus and finally to the amygdala in the brain (LeDoux, 1996). The amygdala is the part of the brain that controls humans fight, flight or freeze response and the hippocampus is what processes if there is real danger or not (LeDoux, 1996). In PTSD symptoms the low road reacts without getting concrete facts if there is indeed real danger. PTSD creates cognitive distortions that prevent the high road from regaining cognitive control creating a fight, flight or freeze response created by the low road without any input from the hippocampus to assess for danger. Individuals will experience trauma triggers when stimuli reminds them of a trauma, which leads to a heightened stress response through the low road between the amygdala and thalamus (LeDoux, 1996). The high road should regain control but PTSD symptoms disturb this process and may prevent the high road from regaining control (LeDoux, 1996). This then causes the hypo and hyperarousal, which continues to keep individuals out of the optimal arousal state where they can receive and integrate information internally and externally that are commonly seen in PTSD (LeDoux, 1996).

Cloitre, Koenen, Cohen and Han (2002) Found that when treating PTSD it is important to first work on skills training that focuses on affective and interpersonal regulation and in doing so will improve a client's overall functioning. With the skills training a positive therapeutic alliance has a chance to be created and affect regulation skills were predictors of PTSD symptom reduction during the use of exposure therapy (Cloitre, Koenen, Cohen, & Han, 2002).

PTSD rarely occurs alone and survivors of trauma will often also experience anxiety, depression, and somatization (Kessler et al., 1995). Somatization is physical, medical symptoms that seem to have no organic cause (Kessler et al., 1995). Also many symptoms of PTSD present and can easily be perceived as another mental health diagnosis such as anxiety, depression, etc. That is why treating PTSD can be so challenging it has many facets and there is not a one size fits all treatment option for PTSD.

Bottom-Up Trauma Theories

Somatic psychology is emerging and becoming more prominent recognizing that body awareness is an essential component to psychological well-being (Caplan, Portillo, & Seely, 2013). Somatic psychology focuses on therapeutic and holistic approaches to the body, and somatic experiences (Caplan, Portillo, & Seely, 2013). Somatic psychology is being researched more and has been found to be effective in treating symptoms of depression, anxiety, PTSD, psychosomatic issues, sexual abuse, and other forms of trauma (Caplan, Portillo, & Seely, 2013). Trauma theorists have recently conceptualized that trauma is stored in the body, brain, and nervous system with this belief being supported by neuroscience research (Caplan, Portillo, & Seely, 2013). This research explains the lack of success and relapse in traditional talk therapy treatments to fully resolve PTSD symptoms (Ogden, Minton, & Pain, 2006). Somatic psychotherapy is a bottom up treatment focusing on the body first and then moving up to connect

the body and mind as an interactive whole (Caplan, Portillo, & Seely, 2013). Even though shifting from psychotherapy strictly focused on the mind to the body is a radical change there are many examples of body oriented PTSD treatment options for example eye movement desensitization and reprocessing (EMDR), which uses bilateral sensory input while an individual recalls distressing events. Sensorimotor psychotherapy is another body oriented approach that tracks body sensation while processing them with integrating cognitive and emotional processing. The neurosequential model of therapeutics is another body oriented approach that utilizes brain mapping to identify areas of the brain that have development and abnormal functioning due to trauma and interventions are created to meet the client where they are developmentally (childtrauma.org, n.d.). Integrative body psychotherapy is another bottom up intervention that helps individuals become deeply aware of their body sensations, emotions, images, and behaviors engaging techniques that bring presence and awareness to the body (Rand, n.d.). Somatic experiencing is another approach that assess where a person is stuck in a fight, flight, or freeze response and provides tools to target the physiological states (Levine, 2008). The goal for body-oriented treatments are that the individual will gain awareness of the connection between emotions and bodily symptoms to regain a feeling of control (Caplan, Portillo, & Seely, 2013).

Top- Down Trauma Theories

Top- down trauma theories believe that change occurs in a top-down direction meaning that change in a client's thought process with exposure treatment or remembering the traumatic event will resolve the client's emotional, behavioral, and physical symptoms (Ogden, Pain, & Fisher, 2006). Theories that work from a top-down focus are trauma- focused cognitive behavioral therapy (TF-CBT), which engages exposure treatment with cognitive processing and

reappraisal, and stress management (Cohen, Mannarino, Berlinger, & Deblinger, 2000). Exposure and cognitive processing allow for clients to rework cognitive distortions related to the trauma to make sense of what has happened to them (Cohen et al., 2000). Stress management incorporates bottom up techniques that involve coping skills such as deep breathing to assist the client through the exposure and cognitive processing (Cohen et al., 2000). Currently the most utilized treatment options for PTSD are Cognitive Behavior Therapy (CBT), which focuses on behavioral activation, changing unhealthy cognitions, and emotion regulation skills (Hobfoll, Blais, Stevens, & Walt, 2016) paired with medication. CBT approaches in the form of Prolonged Exposure (PE), in which clients are prompted to relive their trauma by telling about it in vivid descriptions during a therapy session (Rosaura Polak, Witteveen, Denys & Olff, 2015). Cognitive Processing Therapy (CPT), where clients provide a written account of their trauma while the therapist uses cognitive therapy in session (Walter, Dickstein, Barnes, & Chard, 2014). Due to PE, CPT, and CBT being highly researched interventions they are used most frequently in trauma cases.

Herman's Stages of Trauma Recovery

Judith Herman (1992) identifies a three stages model to trauma recovery which is; a. safety and stabilization, b. remembrance and mourning, c. reconnection and integration. Common themes can emerge in each of the stages that may get in the way of a survivors healing these themes are a. shame and guilt, b. powerlessness, c. distrust, d. reenacting abusive patterns in current relationships (Herman, 1992). When the themes emerge they need to be addressed in any stage so that the survivor can overcome these barriers to achieve the goals in each trauma recovery stage (Herman, 1992).

In each stage there are tasks that are typically done to achieve the goal of the stage. Such as in stage one treatment will be focused on the work that will be done to heal from trauma, setting treatment goals, establishing safety in and stability in one's environment and body, uncovering inner resources for healing, learning emotional regulation skills, and other skills and techniques to manage trauma symptoms (Herman, 1992). The overarching goal of stage one is achieving personal safety, developing self-care techniques, and ability to regulate emotions in a healthy way (Herman, 1992). In stage one there is no focus on the trauma experience itself it is all about safety, inner strength and skill building before entering into processing the trauma, which can be a distressing experience where they will need the skills to help them through it (Herman, 1992).

In stage two, remembrance and mourning takes place through discussing trauma memories to lessen their emotional intensity, work through unresolved grief related to the trauma as well as the negative effects it has had on one's life, and mourn the experiences lost due to the trauma (Herman, 1992). To process through trauma memories methods such as re-experiencing the memories in a safe therapeutic environment are to be used (Herman, 1992). In the third stage, reconnection and integration, the focus is on reconnecting with self, others, and a future not defined by one's trauma experiences (Herman, 1992).

Group Therapy

Group therapy is beneficial because it helps to normalize experiences, provides social support and learning from others who have endured similar struggles (Yalom & Leszcz, 2005). Factors of group therapy that contribute to members healing and growth are universality so that members realize they are not alone in the struggles they are having (Yalom & Leszcz, 2005). Another factor is cohesiveness of the group so that each member feels respected so that bonding

and trust can begin developing within the group (Yalom & Leszcz, 2005). Stige, Rosenvinge, and Traeen (2013) recommend that the therapist and client explore the client's feelings towards being vulnerable, revealing directly or indirectly personal information to others before entering into group therapy to discover if a client is truly ready for group therapy or is needing to enter into a different type of group or treatment option.

Keenan, Lumley, and Schneider (2014) describe that using a group therapy format for the treatment of interpersonal trauma promotes trust and connection within the group by members sharing painful experiences with those who can relate. Group therapy can assist members in reconnecting to themselves and others, overcoming emotional detachment and numbing that are common symptoms of trauma (Keenan, Lumley, & Schneider, 2014). Group therapy also helps members learn how to reconnect with others in the group so that they may take the ability to reconnect and apply it to their relationships outside of group therapy (Keenan, Lumley, & Schneider, 2014). When group members begin to recognize that other members have gone through similar experiences it promotes further discussion of trauma, even leading some members to disclose information that they have never shared (Keenan, Lumley, & Schneider, 2014). The sharing of this hidden information can be contributed to being around others with similar experiences but also the environment of acceptance that the therapist and group members have created (Keenan, Lumley, & Schneider, 2014).

Group therapy formats that are typically used for trauma treatment are support, cognitive-behavioral, and semi-structured groups (Fritch & Lynch, 2008). Support groups consist of process group interventions that focus on current life struggles and coping strategies to combat those struggles (Fritch & Lynch, 2008). Support groups for trauma will not focus on the details of the trauma but instead will focus on the impact of the trauma with group members providing

validation (Fritch & Lynch, 2008). Behavioral groups focus on skill building to decrease fear reactions associated with trauma triggers and build coping skills (Fritch & Lynch, 2008). Cognitive behavioral group therapy has similar goals as a behavioral group but also implements cognitive restructuring by using exposure techniques to decrease trauma related symptoms and improve self-management skills (Fritch & Lynch, 2008). Semi-structured group therapy is present focused addressing member's interpersonal struggles they may be facing through the use of group process (Fritch & Lynch, 2008).

In a study of veterans participating in a trauma focused group Keenan, Lumley and Schneider (2014) found that the veterans began to do activities they once avoided with other group members illustrating how important the aspect of reconnecting to others is in a trauma focused group. In a study conducted by Stige, Rosenvige and Traeen (2013) participants reported that being a part of group therapy and having peer interactions with others that have had similar trauma experiences helped them understand their symptoms better and learn how to cope more effectively with the symptoms. Langmuir, Kirsh, and Classen (2012) found that utilizing sensorimotor psychotherapy in a group therapy for trauma survivors significantly improved symptoms of dissociation and body awareness. Survivors in the group were able to improve their ability to stay present through somatic resources (Langmuir, Kirsh, & Classen, 2012). Though it is not confirmed it is possible that having relationships and the regained connectedness may have strengthened survivor's ability use relationships as an interactive self-soothing technique to help them reduce distress (Langmuir, Kirsh, & Classen, 2012).

Trauma focused group therapy can reach more individuals if groups are not separated into very specific trauma categories but instead focusing on the impact of trauma now in their life rather than the trauma history (Stige, Rosenvige, & Traeen, 2013). Clinical experts continue

to support the use of group therapy with trauma survivors due to the importance of meeting other trauma survivors and for the opportunity to relearn new patterns by revisiting the thoughts and feelings related to the trauma in a safe, accepting environment (Yalom & Leszcz, 2005).

Current Trauma Group Models

Many of the current treatment models for trauma groups follow Herman's (1992) stage model where the focus of the group is on one of the three stages of trauma recovery; a. safety and stabilization, b. remembrance and mourning, c. reconnection and integration. In the stage model for trauma treatment all group members must be at the same stage of recovery to participate in treatment (Mendelsohn et al., 2011). This method is used due to the belief that if group members are not at the same stage the work and goals of the stage would not be able to be done optimally.

Typical trauma groups do not allow for members to have differing traumatic experiences to participate in the same group. For instance, Vandeusen and Carr (2003) separate female group members into childhood sexual abuse and sexual assault due to the potential for harm with group members minimizing their own experience, limiting what they share to the group, and blaming themselves for the trauma. The trauma recovery group model was originally created just for incest survivors and then researchers noticed the group could tolerate heterogeneity in terms of trauma histories (Mendelsohn et al., 2011).

Trauma group interventions that are trauma focused will have members set goals related to the trauma to begin the process of recovery (Vandeusen & Carr, 2003). While the group leaders and members work towards creating a safe environment throughout the group process (Vandeusen & Carr, 2003). Then each member participates in an exposure method of telling one's trauma in as much detail as possible focusing on associated thoughts, feelings, and sensations surrounded by others who have shared similar experiences (Vandeusen & Carr, 2003).

In the trauma recovery group model all members create a goal related to their trauma that is present focused, realistic and achievable, specific, and concrete that will be possible to accomplish with the support of the group (Mendelsohn et al., 2011). In the early stages of the trauma recovery group members tell their trauma story to the group to contextualize their goal and how the goal relates to their trauma with the hope that members will broaden their perspective of their trauma and how it relates to current difficulties (Mendelsohn et al., 2011).

Trauma groups typically struggle for group membership with group leaders needing to spend time marketing by creating posters, flyers, conducting outreach events to reach potential group members. Much time can go to the process of recruiting members by connecting with agencies and clinicians who may provide referrals and once potential members are screened typical group sizes vary from five to eight members (Mendelsohn et al., 2011). Even with all the publicity it is a challenge to form trauma groups with survivors being reluctant to join a group format as a treatment option (Vandeusen & Carr, 2003).

Need for New Interventions

Attracting and retaining members in a trauma-focused group is difficult with the aspect of potentially re-living their trauma as an intimidating factor scaring many participants away from getting the trauma treatment they need. Sloan, Feinstein, Gallagher, Beck, and Keane (2013) found that in the 16 PTSD group therapy treatment studies analyzed the drop out treatment range was between 0-52% with an average rate of 26.5% of participants dropping out of treatment. Also researchers found that group treatment for PTSD did not have any benefits beyond the general benefits of group therapy treatment causing Sloan et al. (2013) to identify the need for alternative approaches to group treatment for PTSD. Numerous forms of exposure treatments are used to treat PTSD in a group format but there is typically a high rate of incomplete response to

treatment (van der Kolk et al., 2014). An example of this is a clinical trial in which prolonged exposure was the treatment, 59% of participants had PTSD symptoms after 12 weeks of treatment and 78% of participants had continued symptoms at the six month follow up (Schnurr, Friedman, Engal, et al., 2007).

According to a meta-analysis by Bradley, Greene, Russ, Dutra, and Westen (2005) they found that 45% of therapy clients with symptoms of PTSD have significant symptoms even after treatment and two-thirds of those who did respond to treatment have a relapse of symptoms within six months. Illustrating that a little less than half of clients completing cognitive behavioral treatment show clinically meaningful symptom improvement (van der Kolk, 2014). The evidence shows that trauma is resistant to treatment so there is a greater need to explore interventions for trauma survivors (Emerson, Sharma, Chaudhry, & Turner, 2009). Organizations such as the Institute of Medicine (IOM) see the need and are calling for more research on complementary and alternative approaches to the treatment of PTSD symptoms (IOM, 2012). IOM has also found scientific evidence lacking for the treatment of PTSD and it does not reach the level of certainty desired for an increasingly common and serious condition (IOM, 2012).

Mindfulness

Mindfulness is defined as a state of keen awareness of physical and mental sensations as they occur through the practice of focusing attention to ourselves without judgment (Follette, Palm & Pearson, 2006). Thoughts and feelings that come up for individuals during mindfulness are not avoided, analyzed, suppressed or judged assisting an individual in awareness of all aspects of themselves (Follette, Palm & Pearson, 2006). Mindfulness is believed to help individuals with self-acceptance through four components commitment, awareness, willingness to experience emotional distress, and focusing on the present moment that are harnessed when

one practices mindfulness (Chodron, 2001). Mindfulness has been used in Buddhist traditions to endure painful emotions rather than the Western traditions to control and overcome negative emotions (Follette, Palm & Pearson, 2006). Experiencing a traumatic event especially an interpersonal trauma a common result is pain and is to be expected in most survivors (Follette, Palm & Pearson, 2001).

Individuals with trauma symptoms exhibit a narrowing of their behavioral responses, which is described as the inability to be mindful or present increasing the use of avoidant behaviors (Follette, Palm & Pearson, 2006). Avoidant behaviors over time will increasingly restrict a trauma survivor's spectrum of life experiences (Follette, Palm & Pearson, 2006). The avoidance becomes a conditioned process that is maintained but mindfulness is a technique that can combat avoidance. Mindfulness based interventions focus on giving attention and acknowledgment to unpleasant emotions, sensations or memories without judgment assist in combating avoidance and suppression that is a symptom of PTSD (Bishop et al., 2004). Mindfulness techniques have reduced emotional distress and symptom severity with a broad range of mental health conditions that have depressive and anxiety symptoms (King, et al., 2013). Mindfulness emphasizes focusing attention on the present moment and acknowledging one's thoughts, feelings, and emotions without judgment (Mitchell et al., 2014). The techniques practiced in mindfulness may help clients reduce avoidance of traumatic memories and allow them to tolerate unpleasant feelings associated with their traumatic experience (Follette, Palm, & Pearson, 2006). Mindfulness assists clients in breaking the behavioral cycle of avoidance and re-creating pathways that raise purposeful and attentive behaviors to the present (Follette, Palm, & Pearson, 2006).

The use of mindfulness skills with clients can address emotional dysregulation, awareness of one's own experiences, and self-acceptance (Follette, Palm, & Pearson, 2006). Another aspect is mindfulness of the relationship assisting a client to stay present during interpersonal interactions may help them in noticing risks and setting limits in relationships (Follette, Palm, & Pearson, 2006). The client can practice mindfulness of relationships with the counselor to model experiencing a safe, nurturing relationship to assist the client in the development of healthy relationships outside of a counseling setting (Follette, Palm, & Pearson, 2006).

The increased popularity of mindfulness and yoga in Westernized countries have led to mind-body focused trauma interventions that can decrease the body's hyper-arousal state that is common in trauma survivors (Mitchell et al., 2014). Mindfulness can help a survivor of trauma develop the ability to focus on the present moment instead of being ruled by their past and fearful of the future (Follette, Palm, & Pearson, 2006). Noticing and engaging with one's own experiences without judgment is something trauma survivors struggle with but mindfulness allows the development of such skills and can lead a survivor to self-acceptance (Follette, Palm, & Pearson, 2006). Allowing survivors to acknowledge thoughts, feelings, and memories without attempting to change them (Follette, Palm, & Pearson, 2006). Mindfulness interventions can be a way to prepare trauma survivors for exposure therapy treatment to assist in engagement in the treatment and assist survivors in emotional reactivity during treatment (King et al., 2013). Mindfulness skills can also assist with combatting avoidant strategies and improve the effectiveness of exposure therapy (Follette, Palm, & Pearson, 2006). Due to the high drop out rate and refusal in trauma focused therapy finding alternatives treatment options such as mindfulness can be beneficial (King et al., 2013).

Psychodrama

Psychodrama is a form of psychotherapy where participants enact or reenact situations that are emotionally significant for them (Fong, 2007). Verbal and non-verbal communication are utilized with scenes ranging from memories of a specific incident in the past, unfinished situations, fantasies, dreams, inner dramas, future risk taking situations, or expressions of mental states in the here and now (Kedem-Tahar & Felix-Kellermann, 1996). The scenes are focused on real life situations or externalizations of inner mental processing that emphasize personal emotional involvement with cognitive integration to connect experiences with awareness through verbalization and processing of the scene (Kedem-Tahar & Felix-Kellermann, 1996). The process of enacting can assist clients in uncovering thoughts and feelings that may not be able to be discovered in a inactive talk therapy format (Konopik & Cheung, 2013). The goal of the acting format is to clarify issues, enhance physical and emotional well-being, encourage communication, assist in skill development, provide insight and the potential of gaining new perspectives (Konopik & Cheung, 2013). Psychodrama has been used with children to older adults from the cognitively impaired and chronically mentally ill population to the fully functioning population (Konopik & Cheung, 2013).

The group format of psychodrama centers on a single person the protagonist each session with the role rotating to a new group member at the next group session (Kipper & Hundal, 2003). Group members play the role of auxiliary egos, which are members chosen by the protagonist to represent persons in the drama acting as therapeutic agents for the protagonist and facilitating the enactment of the many facets of a protagonist's life (Kipper & Hundal, 2003). The roles portrayed by auxiliary egos is focused on what the protagonist wants to work on and not personal

issues of other group members but auxiliaries may gain indirect insight from the portrayals of their roles (Kipper & Hundal, 2003).

The protagonist creates their reality and produces a clinical stage in session (Dayton, 2009). The counselor leads the protagonist with direct questions to enhance the client's intra and/or interpersonal processing through catharsis, action-insight, interpersonal or behavioral learning throughout the group session (Kedem-Tahar & Felix-Kellermann, 1996). Catharsis is a form of purging deep emotions (Dayton, n.d.). Action insight is defined as insight that occurs during reenactment or as a result of reenactment (Dayton, n.d.). In a group setting each member is a therapeutic agent of the other assisting in one another's personal growth and transformation (Fong, 2007). Counselors work in the role of a director while group members become part of the therapeutic production for the protagonist (Clark & Davis-Gage, 2010). Group members who are not in the role of auxiliary egos act as audience members witnessing the protagonist's story unfold.

The session format in psychodrama begins with a warm up to get in touch with oneself and issues the group and/ or the protagonist wants to explore (Dayton, 2009). Then the action stage portion of the session takes place, which is the actual role-play (Kipper & Hundal, 2003). The sessions come to a close by processing what happened throughout the production and sharing personal revelations that the protagonist and group members may have had from experiencing or witnessing the role-play (Fong, 2007). Group leaders assist in the process by including various process questions, thoughts and reactions to activities, and members sharing feelings that may have come up for them during each other's psychodramas (Clark & Davis-Gage, 2010). In the safe context of a session the protagonist is able to re-inhabit the body that has

experienced the trauma, to slow it down and replay safely to make meaning in the cognitive side of their brain (Dayton, 2009).

Psychodrama has limited recent research and literature; a few studies do discuss the incorporation of psychodrama as part of the treatment modality. For instance, Rademaker, Vermetten, and Kleber (2009) incorporated psychodrama as an adjunctive treatment to assist in the resolution of emotional problems and facilitate therapeutic progress in a PTSD treatment program for the United Nations (UN) veterans in an outpatient program. Pre and posttest comparison showed a decrease in depression, anxiety and somatic symptoms associated with PTSD (Rademaker, Vermetten, & Kleber, 2009). Improvements were also made in participants coping strategies, self-esteem, and self reported work related problems (Rademaker, Vermetten, & Kleber, 2009).

In another study conducted by Carbonell and Parteleno-Barehmi (1999) evaluated the effectiveness of a psychodrama group with traumatized middle school girls. Twenty-six girls between eleven and thirteen participated and were randomly selected to be in the treatment or waitlist group (Carbonell & Parteleno-Barehmi, 1999). The traumas the participants had experienced ranged from sexual abuse, the murder of a family member, physical abuse, suicide by a family member, witnessing a violent event, being in an accident, parental drug/alcohol abuse, experiencing a fire (Carbonell & Parteleno-Barehmi, 1999). The study found significant reduction in withdrawn behavior and anxiety/depression, which are common symptoms of PTSD (Carbonell & Parteleno-Barehmi, 1999). Utilizing psychodrama as the group format helped increase trust, cohesion, and positive attachments among group members (Carbonell & Parteleno-Barehmi, 1999). In post interviews researchers found a strong theme of healing among group participants in terms of access to a larger range of coping techniques, the opportunity to

help others with similar trauma histories, and feeling supported by a group who understood them and gave them strength during painful re-enactments (Carbonell & Parteleno-Barehmi, 1999).

Utilizing psychodrama with survivors of trauma encourages clients to become aware of their bodies, using their bodies as a medium as well as verbal communication to discover personal truths and heal from trauma (Fong, 2007). The past is brought to the here and now giving the client the opportunity to process through memories, unfinished situation, inner dramas with the guidance of the counselor directing them (Kipper, 1998). Trauma impacts the mind as well as the body so treatment approaches should address both, which is the goal of psychodrama (Clark & Davis-Gage, 2010). The enactment is not meant to deny one's trauma experience but instead restructure it so that the individual can gain a new understanding (Carbonell &Parteleno-Barehmi, 1999). Trauma survivors can also begin to reframe victimization as survival, helplessness as a subjective state rather than reality, and the future as hopeful rather than painful (Carbonell &Parteleno-Barehmi, 1999). Psychodrama offers a space to reframe as well as rework the trauma in all senses since the enactment contains sights, sounds, smells and feelings associated with the traumatic event giving the survivor control to rework the trauma (Carbonell &Parteleno-Barehmi, 1999). Restoring the survivor's sense of control and hope that the traumatic event took away (Carbonell &Parteleno-Barehmi, 1999).

Yoga

Yoga is among the sixth most widely practiced complementary heath treatments in the United States with an estimated 21 million individuals practicing regularly in the United States (NIH, 2015). Yoga can be viewed as a mindfulness technique that incorporates physical poses and breath work that places an emphasis on emotional and physical awareness without judgement (Mitchell, 2014). Yoga consists of not only physical postures but breath work and

meditation that are believed to all be beneficial in reducing PTSD symptoms (van der Kolk, 2014).

Telles, Singh, and Balkrishna (2012) believe that yoga assists individuals in regaining a sense of being in control of their lives and increases self-dependence by requiring involvement and by being an individually practiced activity. Yoga can also increase mind-body awareness and increase resilience, which are concepts both practiced in counseling (Khalsa, 2004). The field of counseling is seeing a trend of alternative practices such as the use of meditation, yoga, and mindfulness. There has been a call for an increase in research in alternative and complementary approaches for PTSD by the Institute of Medicine (IOM, 2012). Traditional talk therapy techniques address cognitive and emotional damage done by trauma but it does not address the physiological side of the trauma (Griffin, 2011).

Research has shown that trauma survivors internal alarm system is on overdrive and research has shown that yoga can help quiet the internal alarm system, help survivors feel more comfortable in their body and mind and assist in feeling calmer (Griffin, 2011). There are many positive effects of short and long term yoga practices such as reducing stress responses and decreasing hyperarousal symptoms (Ross & Thomas, 2010). Counselors utilizing alternative treatment options have been studied such as van der Kolk (2006) comparing eight sessions of hatha yoga or dialectical behavior therapy for a small group of women. Hatha yoga is simply the practice of physical yoga postures and dialectical behavior therapy is a cognitive behavioral treatment that assists clients in emotional and cognitive regulation. The findings were that the women in the hatha yoga group had significant reductions of symptoms of intrusions, hyperarousal, negative affect and were more attuned with their body than the dialectical behavior therapy group (van der Kolk, 2006).

In a study conducted by Mitchell et al. (2014) woman who met criteria for PTSD symptoms were randomly assigned to a control or treatment group; the treatment group participated in a form of hatha yoga that lasted for 75 minutes over the period of six or 12 weeks depending on the number of classes participants wanted to go to in a week. The yoga group had significant decreases in re-experiencing and hyperarousal symptoms associated with PTSD (Mitchell et al., 2014). In Pence, Katz, Huffman, and Cojucar's (2014) study of incorporating yoga nidra, which is a type of yoga and meditation that mimics the going to sleep phase into the treatment for sexual assault survivors they found significant improvements with PTSD, depression and self-blame in participants between their pre and post assessments. Another study composed of women who had experienced abuse as adults or children engaged in frequent yoga practices reported positive self-concept and low rates of dysfunctional coping mechanisms (Dale et al., 2011).

Van der Kolk et al. (2014) utilized yoga as an adjunct treatment randomly assigning participants to a control group that was structured as a supportive women's health group or the treatment group that was a trauma-informed yoga group. Both groups had significant decreases in PTSD symptoms half way through the treatment but the control group members relapsed in their symptomology while the yoga group maintained their symptom reduction (van der Kolk el at., 2014). At the end of the study 52% of women in the yoga group no longer met the criteria for PTSD compared to 21% of women in the control group (van der Kolk, 2014).

Yoga has become an increasingly used non-pharmaceutical approach to trauma symptom treatments caused by natural disasters, combat and terrorism, interpersonal violence, and incarceration (Telles, Signh, & Balkrishna, 2012). Studies investigating the effects of yoga on brain chemistry have showed that a regular yoga practice can improve gamma amino butyric acid

(GABA), which is associated with a decrease in anxiety and an improved mood (Telles, Signh, & Balkrishna, 2012). GABA improvements are typically established by pharmacological agents, which shows that a yoga intervention may produce some of the same outcomes as prescription medication (Telles, Signh, & Balkrishna, 2012).

Emerson, Sharma, Chaudhry, and Turner (2009) believe that yoga is a promising intervention to assist clients who have symptoms associated with trauma because of the recent findings that yoga can reduce muscle tension, blood pressure, emotional distress and potentially increase the quality of ones life. Yoga works to decrease and regulate the stress response, which can decrease PTSD symptoms (Mitchell et al., 2014). Incorporating yoga into trauma therapy can be a way to ease the survivor back into a positive relationship with their body through focusing on breath and gentle movement practices (Emerson, Sharma, Chaudhry, & Turner, 2009). As Mitchell et al. (2014) point out that yoga is popular and that may appeal to clients and assist in retention rates in a clinical setting as well.

Posttraumatic Growth Theory

Positive psychology has identified a theory of posttraumatic growth after adverse life events happen to an individual. Posttraumatic growth can be defined as an individual's development superseding in some areas what was present before the trauma occurred (Tedeschi & Calhoun, 2004). A qualitative change in functioning occurs for the individual with new schemas developing and becoming a part of the individual's worldview (Chopko & Schwartz, 2009). The growth in posttraumatic growth does not happen from the trauma itself but from the individual's struggle to make meaning of their new reality after trauma (Tedeschi & Calhoun, 2004). Five domains of posttraumatic growth have been identified with a. being a greater appreciation for life and changed sense of priorities, b. more intimate relationships with others, c.

a greater sense of personal strength, d. recognition of new possibilities for life, e. spiritual development (Tedeschi & Calhoun, 1996). Tedeschi and Calhoun (2004) found that posttraumatic growth experiences after a trauma event outnumbered reports of disorders.

Joseph and Linley (2006) reviewed 39 empirical studies that identified positive changes and growth following adverse events finding that coping style, optimism, and perception of positive effects were all associated with growth. The study also found that individuals who report and continue growth after trauma are less distressed in the future (Joseph & Linley, 2006). Prati and Pietrantoni (2009) found in a meta-analysis of 103 studies showed that interventions aimed at increasing social support, optimism, and coping strategies have potential to promote positive changes after a trauma occurs. As Almedom (2005) discussed posttraumatic growth and resiliency reveals light at the end of the tunnel after a trauma happens to an individual,

Summary

In summary, the following chapter provides a literature review relevant to the current research study. Highlighting key concepts such as interpersonal trauma, PTSD, high road vs the low road, group therapy and the group therapy interventions to be utilized which are mindfulness, psychodrama and yoga. There is a multitude of research out there regarding interpersonal trauma and interventions that are cognitively focused for trauma survivors so providing one that engages psychological as well as physiological interventions to interpersonal trauma survivors is of specific interest. In the following Chapter three, methods and plans for data analysis are presented.

Chapter Three: Methods

Overview

In the following chapter the research methods are discussed. Including further details on the research timeline, the case being studied participants, and setting. The design used is a qualitative single, explanatory case study research design to explore the lived experience of interpersonal trauma survivors that participate in a group therapy format that incorporates psychological and physiological approaches. To link the group process to the impacts of the group I sought to answer the following research questions.

1. How do interpersonal violence survivors and group facilitators describe the process and elements of a group therapy modality that incorporates psychological and physiological approaches?
    a. How do interpersonal violence survivors perceive a group therapy modality that incorporates psychological and physiological approaches?
    b. How do facilitators perceive a group therapy modality that incorporates psychological and physiological approaches?

The Qualitative Paradigm

A qualitative research design was used for the study working from a constructivist paradigm. With the researcher working from a constructivist paradigm assumptions are that the inquiries being made in the study are individual perspectives and a construction of their reality, which may share some similarities with individuals from their social group but multiple realities exist because all humans experience the world differently (Hatch, 2002). From the paradigm researchers and participants are the ones to construct the reality that is being investigated so the researcher will be immersed in the world being studied (Hatch, 2002).

In the study of the effectiveness of a therapy group designed for interpersonal trauma survivors it is vital that respectful, trusting, and fair rapport is established between the group participants and I not just for the data collected but because myself and participants were immersed together throughout the group therapy process. The values of the research align with the American Counseling Association's (2014) view of trust being the cornerstone of the counseling relationship.

Research Design and Timeline

At the outset, institutional review board (IRB) approval was granted before participants were referred to the group. Please see appendix B for the IRB approval. Graduate and undergraduate students who have experienced interpersonal trauma at some point in their life who attend a public university in the mid-south were referred to the group from senior clinicians and counseling interns at the college counseling center. This process was continued until a minimum sample size of four to six participants was reached or surpassed. Participants were contacted prior to the group beginning to discuss the group and the study. Participants and I chose a convenient time for the interview to be completed and the interviews took place at the college-counseling center on campus. Each interview lasted 15-30 minutes, with all sessions being video recorded and transcribed. I also interviewed the group facilitators and the yoga instructor with interviews being audio recorded and lasted 30-60 minutes. The interviews were encrypted on a password-protected computer and when transcribed hard copies of interviews were locked in a file cabinet in a locked office.

Creswell (2013) defines case studies as a qualitative approach investigating a case composed of a real life system through in depth data collection from multiple sources such as interviews, observations, audiovisual material, documents utilized to create a case description

and case themes. Case studies have been found to be applicable when the researcher is interested in a process (Merriam, 1998). A process in a case study context is describing the situation and population of the study and understanding a treatment or program that has been implemented then providing feedback to the program (Merriam, 1998). Instead of providing an outcome case studies assist in understanding processes of programs, events, and projects and to discover characteristics that deepen our awareness of an issue or object (Merriam, 1998).

The case being investigated is the Reconnection group with the intent of exploring the group elements and process by gaining insight from group members', group facilitators', and the yoga instructor and from observations that I made. Including the representation of multiple perspectives by interviewing each group member, the group facilitators, and the yoga instructor the details provided a complete and dependable account of the group under study (Merriam, 1998). Collecting detailed data from interviews with group members, leaders, and the yoga instructor and through observations the data collected created case descriptions and case themes leading to conclusions formed by me about the overall meaning or explanations as Yin (2009) labeled overall case conclusions. An aspect of case study methods that should be noted is that there is not a comprehensive or standard catalog of research designs yet developed for case study research (Yin, 2014).

The research design used that aligns with the paradigm is a single, explanatory case study because the research investigated a group therapy treatment that incorporates psychological and physiological interventions to better understand the group elements and process. Explanatory case studies have a goal of explaining how and why some events happen (Yin, 2003). Case study designs are chosen in research designs to gain insight, discovery, and interpretation rather than test hypotheses (Merriam, 1998).

Yin (2009) identified five components of effective case study research design: (a) research question; (b) propositions or purpose of the study; (c) unit of analysis; (d) logic that links data to propositions; and (e) criteria for interpreting findings. The most appropriate questions for case studies are focused on how and why to get rich in depth data. Keeping in mind the goal of getting rich in depth data I focused on how group members as well as group facilitators and the yoga instructor described the experience of participating in a group that incorporates psychological and physiological approaches. Yin's (2009) second component of case study design is to clearly define the purpose of the study. The purpose of this case study is to understand the elements and process of a trauma group treatment modality that utilizes psychodrama as the primary treatment option and incorporates mindfulness and yoga as adjunctive treatments with individuals who have experienced interpersonal trauma. Yin (2009) defined the unit of analysis as the area of focus as the third component of effective case study research. The current study area of focus is on the Reconnection group as the case to be analyzed. As data was collected, coded, and analyzed with themes emerging, the data are then linked to the purpose of the study to answer the research question posed. The fifth component involves the researcher coding the data to allow the codes to develop into themes. To develop themes, I spent time reading the transcripts, reviewing field notes, coding and rereading the data.

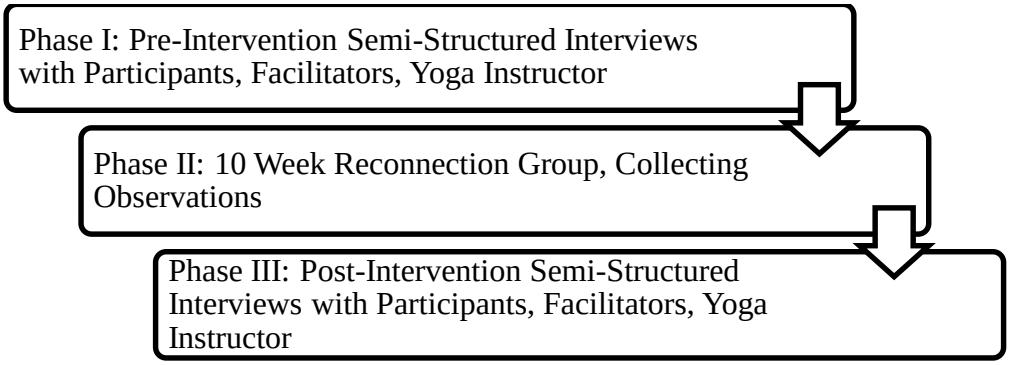
To collect interviews prior to the start of group I contacted potential members who had been referred to the group to discuss the research study with them, get their verbal consent, and schedule a one on one semi-structured interview. I also contacted the group facilitators and the yoga instructor prior to the group starting for verbal consent to participate in the study, and schedule a one on one semi-structured interview. Interviews took place at the college counseling center the week prior to the group starting and the week after the group ended. Before starting

the interviews I reviewed the consent form with participants, and they signed form. I video recorded the interviews to observe body language of group participants and I transcribed the interviews verbatim. The interviews of the group facilitators and the yoga instructor were audio recorded and transcribed. Observation notes were made throughout the 10-week group and a final semi-structured interview took place once group ended; the interviews were video recorded to document changes in body language of group participants and transcribed. At the end of the group final semi-structured interviews were completed with group facilitators and the yoga instructor; the interview was audio recorded and transcribed.

A unique aspect of case study that differs from methods such as experimental, survey, and historical research is that there is not a particular method for data collection or data analysis (Merriam, 1998). Any and all methods for data collection can be utilized in case study design although some techniques are more popular to use than others (Merriam, 1998). To analyze the data, I thoroughly engaged with the descriptions that participants provided through their transcriptions to understand the meaning and find case descriptions and case themes throughout the transcriptions. Below is a table illustrating the phases in which the research was conducted.

Figure 3.1

Summary of Research Phases



Researcher as the Instrument

I am a licensed associate counselor with a masters degree in school counseling and all of the course work completed for my PhD. I have been doing clinical work for two years at an inpatient hospital and a college counseling center. I work from a person centered theory and emotionally focused theory in my work with trauma survivors. In my work as a clinician it has become apparent to me that there is a gap in evidence based trauma treatment options for interpersonal trauma survivors. Yes, re-experiencing symptoms can be diminished but the emotional numbing and dissociation from the body, themselves and others is not addressed. I believe to live a fulfilling life and regain a sense of control over one's own life these areas need to be addressed and worked on so that survivors can accomplish that. I do not know if the Reconnection group is necessarily an answer to this gap but I think it is an area to explore and continue growing the exploration of trauma treatment options. I believe being invested in the exploration process for trauma treatment options helps limit my professional bias as well as my ability to see the value in the evidence based trauma treatment methods. Counseling interventions are not a one size fits all approach which also allows me to understand that the Reconnection group may not be a good fit for everyone allowing me to stay objective in the group process and research. I do have a bias since I have co-facilitated the Reconnection group for the past year and half but to set that aside to really look deeper at the group I utilized supervision and reflexivity. Also bringing the open codes and case themes to group members allowed for the bias that may have emerged in data analysis to be decreased because of the feedback I got about accurately portraying the group member's experiences. My training in qualitative research has been taking two classes at the doctorate level on qualitative research

methods and advanced qualitative research methods. I also have done a lot of reading specifically on case studies to equip me to be successful in writing this research manuscript.

In my personal life I lost my mother to intimate partner violence and I was a witness to her abuse as well as her death. The experience of being raised in a violent environment, the loss of my mother, and my own therapy treatment is what has motivated me and made me passionate about working with interpersonal trauma survivors. To keep my personal bias out of my work with interpersonal trauma survivors I engage in continued supervision as well as my own therapy as needed. Having a co-facilitator for the Reconnection group also helps maintain my objectivity.

Data Sources

The current research study was conducted at a public university in the mid-south with a total enrollment around 27,000 students. The study took place at the university's counseling center, which offers a variety of individual and group counseling options. Participants were referred to the group by clinicians at the counseling center through purposive sampling methods because each participant whether male or female must have an interpersonal trauma experience. Another requirement of the group is that each participant has previously or is currently receiving individual counseling regarding their trauma. The group is a closed group meaning members must be referred and meet with the facilitator prior to attending the group to ensure the group is a good fit for each participant.

Unlike other trauma focused groups the format of the Reconnection group does not require every member to have experienced the same interpersonal trauma. Participants were both male and female undergraduate and graduate students at the university. Mixing the group with both male and female participants is another aspect of the Reconnection group that is not done in other trauma focused group formats, which helps provide increased treatment options to

interpersonal trauma survivors instead of turning them away due to gender or not having experienced the same interpersonal trauma. The target number of participants to conduct the group and research was four to six participants.

The completion of an informed consent document was required for participants, group facilitators, and the yoga instructor; I explained this document to all prior to the interview. Please see appendix A for the informed consent. Basic demographic data was collected including age, gender, year in school and additional information relevant to their interpersonal trauma experience and posttraumatic stress (PTSD) symptoms. Followed by semi-structured interviews with predefined questions that are focused on the research question. The format of semi-structured interviews allows the interviews to be flexible and fluid to each participant's experience. Interview questions can be found in appendix C and D. Observation notes of participant's body language from pre and post interviews were also assessed. Field notes of each group session themes were also collected throughout the duration of the 10-week group to analyze and triangulate with the interviews and the body language assessment.

Semi-structured interviews were utilized prior to the group starting to explore group member's expectations, thoughts and feelings they were bringing into the group with them. The interviews were transcribed and group members, group facilitators, and the yoga instructor all read through their transcriptions to confirm that they had been accurately represented. Pre-group interview sub-categories were presented to participants, group facilitators, and the yoga instructor to identify the overarching categories that they would assign to the data. As well as presenting the overarching categories that I developed. Through open discussion, formatting and reformatting the group members, group facilitators, and yoga instructor agreed on the categories and how they best represented their experience of entering into the group. Member checks were

utilized numerous times throughout the research first by having all interviewees decide if there were any further questions that needed to be added to the interview, second by reading through their transcriptions to ensure they were accurately portrayed, and third by being presented with sub-categories and categories to best represent their experience prior to entering into the group.

Semi-structured interviews were utilized at the end of group to explore group member's experience of participating in a group for interpersonal trauma survivors that incorporated psychological and physiological approaches. The interviews were transcribed and group members who were accessible, group facilitators, and the yoga instructor all read through their transcriptions to confirm that they had been accurately represented. Post-group interview sub-categories were presented to participants, group facilitators, and the yoga instructor to identify the overarching categories that they would assign to the data. As well as presenting the overarching categories that I developed. Through open discussion, formatting and reformatting the group members, group facilitators, and yoga instructor agreed on the categories and how they best represented their experience in the group. Member checks were utilized numerous times throughout the research first by having all interviewees decide if there were any further questions that needed to be added to the interview, second by reading through their transcriptions to ensure they were accurately portrayed, and third by being presented with sub-categories and categories to best represent their experience in the group. Participant four did not end up attending group, after three-group sessions participant eight discontinued coming to group and halfway through the group participant five chose to discontinue as well. Both participant's five and eight self-identified as not being ready for the emotional intensity of the group. In the post group interviews descriptions were collected from five members compared to pre group interviews that were collected from eight members.

Data Analysis

Data analysis can be defined as a systemic search for meaning (Hatch, 2002). Data analysis is a way to process what has been collected in qualitative research so then what is learned can be shared with others (Hatch, 2002). During data analysis information gained through interviews, observations, etc. were organized and examined in ways that assisted me to see patterns, themes, relationships, explanations, and interpretations.

All recordings were transcribed; the data was verified by reading through the transcripts while listening to the recordings. Once verified, the data was analyzed using a single, explanatory case study approach by looking for common case themes and case descriptions that relate directly to the study's research question. Collective case themes and descriptions examining the group of participants as a whole were addressed as well as individual case themes that are unique to one or a few group participants. Key meanings were understood by working with the interviewees so that the data could be fully understood. Preliminary themes were found for each participant interview using open coding from themes that emerged from each transcribed interview. Then all individual themes were combined and examined for themes across cases. Finally, I developed case themes and overall case conclusions.

Criteria for Judging the Quality of Research Design

In qualitative research designs there are four design tests to judge the quality of the research design (Yin, 2014). The four tests are a. construct validity, b. internal validity, c. external validity, and d. reliability (Yin, 2014). For case study designs procedures to address these tests should be utilized throughout the research process (Yin, 2014).

Construct validity can be defined as identifying measures for the concepts being studied to see if research is really measuring what it claims to be measuring (Yin, 2014). Internal validity

is defined as certain conditions being believed to lead to other conditions, establishing a relationship between the two, avoiding having more than one independent variable (Yin, 2014). External validity is the extent to which the study's findings can be generalized to other situations and populations (Yin, 2014). Reliability is the concept that if the study was repeated with the same procedures the same results would be found (Yin, 2014).

To achieve construct validity multiple sources of evidence were collected such as group participant's self-report, my observations during groups, field notes, group facilitators' reports and the yoga instructor's report. Also to ensure construct validity member checks were utilized to for validity in member interviews as well as when case themes were developed.

To achieve internal validity and explain the relationships found other factors must be considered to have caused or created the relationship as well (Yin, 2014). Another concern of internal validity is the inferences the researcher makes without directly observing such as inferences made from interviews and documents (Yin, 2014). In addition, achieving internal validity in the current study procedures were taken place during the data analysis phase such as pattern matching with the Reconnection group and member's self-report as well as observations of experience or not experiencing improvements. Explanation building was used in data analysis process to explain how and why connections happened through the Reconnection group and the outcomes perceived with the goal of developing ideas further to study in the future (Yin, 2014).

To achieve external validity, the first step is choosing to conduct a case study and having research questions that align with case study designs such as "how" or "why" questions (Yin, 2014). The groundwork is then created at the beginning of the research to obtain external validity (Yin, 2014). As in qualitative research the findings cannot be generalized to the entire population

but it can aid in the development of further studies that may be generalizable to interpersonal trauma survivors.

To achieve reliability, the need is for thorough documentation of procedures so that the study could be replicated with the same results (Yin, 2014). To achieve this in the current case study notes were taken over what was done each group session as well as procedures that happened for pre and post group interviews to take place. Also interview questions are included in the current study, please see appendix C for pre group interview questions and appendix D for post group interview questions.

In sum, I had taken steps to ensure construct validity, internal validity, external validity, and reliability. Techniques can be utilized throughout the research process that will aid in the validity and reliability of data collected. Such techniques are prolonged engagement, peer debriefing, reflexivity, member checks and triangulation.

Prolonged Engagement. The process of prolonged engagement ensures the researcher spends enough time in the environment in order to understand the central phenomenon (Cohen & Crabtree, 2006). Prolonged engagement can assist in building rapport with research participants developed on trust and understanding to co-construct meaning between the members and the researcher (Cohen & Crabtree, 2006). To ensure prolonged engagement I was the one who conducted interviews prior to group starting as well as at the end of the group. I also co-facilitated the group and attended every group session.

Peer Debriefing. The process of peer debriefing allows for neutral colleagues to examine the study's semi-structured interviews, methodology, transcripts, and data analysis to provide feedback to the researcher (Cohen & Crabtree, 2006). This allows for new insights and a decrease in researcher bias that may have been overlooked and can help provide validity and

credibility to the research (Cohen & Crabtree, 2006). Peer debriefing took place with a licensed professional counselor who has experience working with veterans in trauma groups.

Reflexivity. Reflexivity is an ongoing process throughout the research study to ensure the researcher's continued awareness that any actions the researcher takes may impact the outcomes of the study (Cohen & Crabtree, 2006). This continued awareness is necessary since I conducted the group process as well as collecting and analyzing the data. Reflexivity was maintained through a reflexive journal to record methodological decisions that I made and the reasoning behind them, logistics of the study, and reflection upon what is emerging throughout the study with the researcher's intrapersonal experience with it (Cohen & Crabtree, 2006). Also I am reporting research perspectives, values, positions and beliefs in the current research manuscript as well as in any future publications on the research.

Member Checks. I utilized member checks throughout the data analysis process to ensure that participant's experiences were represented accurately. Transcriptions were shared with participants giving the participants an opportunity to clarify or correct anything. None of the members had anything to add but many addressed that they wished they would have been more concise with their responses. Coding was also shared with the participants to hear their feedback on case themes then I shared the case themes I developed for their feedback. Group members did combine case themes I had and agreed that this accurately portrayed their experiences. Member checks increase validity in the design by receiving feedback from participants and reliability since the data is corroborated by the participants (Cohen & Crabtree, 2006).

Triangulation. Yin (2009) stated that a carefully conducted case study benefits from having multiple sources of evidence to ensure the study is as robust as possible. It is important to converge multiple sources of data to triangulate the data as a way to ensure results that reflect the

participant's experience as accurately as possible. I will use triangulation; which means to use multiple sources of data to increase the validity of qualitative research. The multiple sources of data are interviews with group members, group facilitators, and the yoga instructor for the Reconnection group as well as my observations during the group. Having multiple sources of data will help support the findings from the research study.

Ethical Considerations

Permission was obtained from the IRB. Group participants were made aware that their privacy is protected; no results individual or aggregated, will be tracked to a single participant. Once the research is finished recordings will be deleted. Group participants also understood that reflection on current or past events experienced may cause emotional distress and that they could end the interview at any time if needed.

Summary

This chapter discussed the research procedures describing the process and elements of a group that incorporates psychological and physiological interventions. The data sources included group participant's interviews, group facilitator interviews, yoga instruction interviews, my field notes, and observations. The data was analyzed from a single, explanatory case study perspective. The results are presented in Chapter four of the dissertation with a discussion of the conclusions drawn presented in Chapter five.

Chapter Four: Findings

Overview

In this chapter the purpose of the study and research questions will be reviewed and demographic data of group members will be provided. The case description, case themes and overall case conclusion will be described to share the findings of the research study.

Purpose of the Study and Research Questions

As stated in Chapter one, the purpose of this qualitative explanatory case study is to understand the process and elements of a trauma group approach that utilizes psychodrama as the primary treatment option and incorporates mindfulness and yoga as adjunctive treatments. Of specific interest is the physiological and psychological impact that this approach will have on survivors of interpersonal trauma. The research question that guided pre and post group interviews was interpersonal violence survivors and group facilitators describe the process and elements of a group therapy modality that incorporates psychological and physiological approaches? The sub questions were how do interpersonal violence survivors perceive a group therapy modality that incorporates psychological and physiological approaches and how do facilitators perceive a group therapy modality that incorporates psychological and physiological approaches?

The results of this case study tell a story about how eight interpersonal trauma survivors experienced a 10-week therapy group that incorporated psychological and physiological approaches. Multiple sources of data collection were utilized; this chapter is divided into sections describing the information gathered from each source with a full overview of the overall emerging themes.

Case Description

Group participants ages ranged from 18-32 with the median age being 19.25 years old with the majority of participants being female with one male participant. The majority of the participants were in undergraduate with two participants in graduate school. All participants had experienced an interpersonal trauma with the majority of traumas occurring in childhood. The below table illustrates the group member's demographics.

Table 4.1

Summary of Participants Characteristics

Participant Identification Number	Age Range	Gender	Year in College	Interpersonal Trauma Experience
1	18-25	F	Freshman	Childhood physical and emotional abuse
2	25-32	F	Graduate Student	Childhood neglect, childhood sexual abuse, sexual assault, domestic violence
3	18-25	F	Graduate Student	Sexual assault
4	18-25	F	Junior	Childhood sexual abuse
5	18-25	F	Sophomore	Childhood sexual abuse
6	25-32	M	Senior	Childhood sexual abuse
7	18-25	F	Freshman	Childhood sexual abuse, sexual assault and domestic violence
8	18-25	F	Senior	Childhood emotional and sexual abuse

The yoga instructor leading the yoga portion of group is a certified yoga instructor who continues to participate in continuing education on yoga. I was one of the group facilitators and I am a licensed associate counselor with two years of clinical experience in an inpatient and college counseling center setting. The other group facilitator is a licensed professional counselor

with 10 years of experience working at a college counseling center and a certified clinical trauma specialist.

The format of the first group session is to go over introductions, group rules and educate clients about PTSD symptoms and the rationale for the group format. Time is taken in group for questions and to normalize the feelings of discomfort. Every session allows for a 5-minute transition time from group to yoga allowing time to set up the room, change clothes, and to get yoga mats set up. During the first group session yoga lasts 60 minutes allowing the yoga instructor time for introductions, introduction to yoga, goals of yoga and a 45-50-minute yoga practice.

The second session starts with an icebreaker activity of walking around the room with their eyes closed and discussing the distress that causes and normalizing the distress and discomfort. Then the focus is on introducing empathy to group members by watching the Brene Brown short clip on empathy, discussing the importance of empathy for connection, and practicing empathy statements in a fishbowl exercise. Similar to the first session, yoga typically lasts between 30-60 minutes. The first two yoga sessions mainly consist of "slow flow" poses focusing on mindfully observing emotional and physical reactions to lightly stretching and then relaxing various muscle groups while regulating breath. The group leaders are not in the room during yoga, but are available for consultation if a group member becomes distressed and needs to leave the room.

The third session introduces skills to help with self-regulation such as the emotional freedom technique (EFT), mindfulness practices, grounding techniques, and breath work. The EFT or otherwise called thought field therapy (TFT) or tapping involves using the meridian points on the body that are thought to be energy centers and tapping along them with one's finger

tips (Waite & Holder, 2003). It is believed that the tapping will restore energy flow as well as eliminate negative emotions and distress (Waite & Holder, 2003). Mindfulness practices are utilized at the beginning of each session starting on the third session, spending about five to 10 minutes on a mindfulness technique. A variety of mindfulness activities are used such as body scans, guided imagery, focus on being present with thoughts or a specific body part. Grounding techniques are used to assist group member's in gaining a sense of control and safety when they are feeling distress by identifying objects they identify in the room using their five senses of touch, taste, sound, sight, and smell. The use of grounding techniques assists the client in coming back to the here and now when they encounter a trigger that engages their trauma response. Breath work are techniques of bringing awareness to and controlling breathing. Breath work can be as simple as inhaling for a count of four and exhaling for a count of four.

The skills and techniques are intended to be a continuous practice for the group members so that they can pick and choose what skills work best for their individualized needs. The skills are away to regain emotional regulation and presence in the body when one is feeling overcome with the symptoms of trauma. Time is spent discussing a recap of the previous session discussion over empathy as well as time to process the skills learned and introduce the format of psychodramas that will begin taking place in session four. The group then does 30-60 minutes of yoga together.

The fourth session begins with a mindfulness exercise led by a group facilitator and time is spent processing how the activity went for group members. The group facilitators recap the format of psychodramas and answer any questions about psychodrama. Then group members are invited to volunteer to be in the role of the protagonist meaning that the session will focus on the one individual who volunteers. While in the role of the protagonist clients are encouraged to

process through an unresolved trauma-related conflict that they may never be able to complete in real life. As van der Kolk (2014) explained allowing clients to physically re-experience the past in the present can be a powerful way to rework situations and relationships into new supplemental memories that are created in a safe, supportive environment.

The following sessions continue with the format of a mindfulness activity to engage body awareness, one psychodrama and group processing at the end of the session with a 30-45-minute yoga session after group. Typically, the 30-45-minute yoga sessions are more physically demanding by encouraging more movement and quicker succession of poses. These yoga sessions are designed to help clients discharge the physical and emotional tension created during the psychodrama portion of group which helps simulate completion of a fight or flight reaction and combats a freeze response. The group progresses in this format to give every group member an opportunity to be in the role of the protagonist.

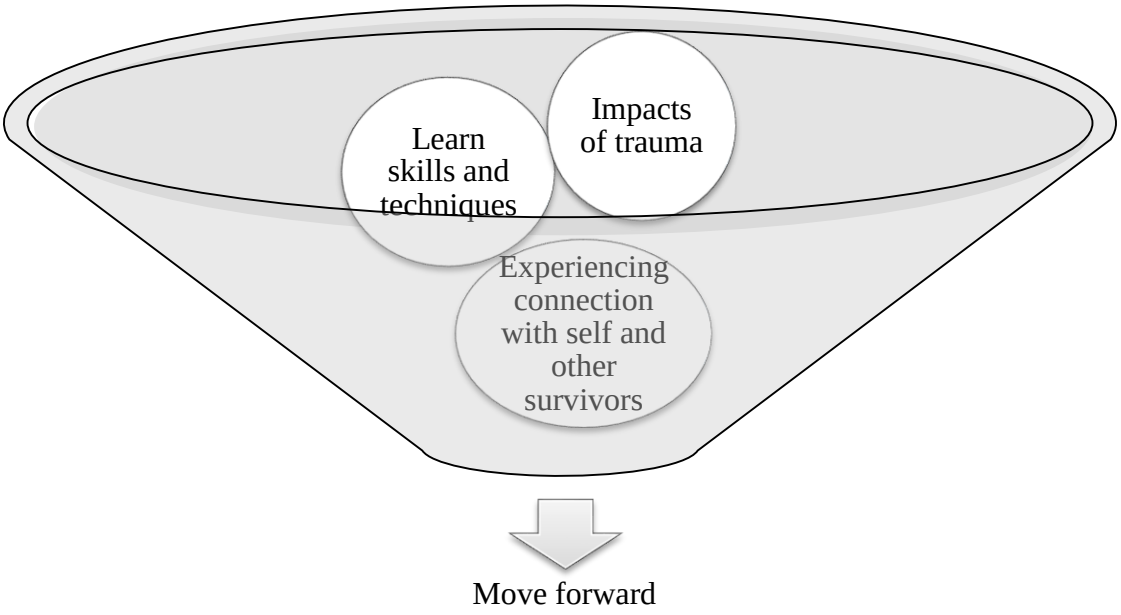
The last session group members have an opportunity to provide feedback about the group by discussing what they enjoyed, what was helpful, what was not helpful, what changes they think need to be made, how they plan to implement what they gained from group in their lives to continue their progress and their overall experience of group. Group members are allowed to participate in the group again the following semester if they believe this would be helpful to them. Group members spend the last session doing a 60-minute yoga class together.

Case Themes

The group members have all experienced the impacts of trauma and they identified feeling alone and disconnected from others and themselves. Group members believe that the group can help them learn skills, techniques as well as being around other trauma survivors to help them understand themselves, gain connection and move forward in their lives from their past traumas.

Figure 4.1

Pre-Group Case Themes



Impacts of trauma. The category of impacts of trauma emerged from the semi-structured interviews as well as through observation of the group. The interviews were not focused on the participant's specific trauma history or symptoms and open ended questions did not lead participants to describe their impacts of trauma but yet it emerged in the data. The impacts of trauma were compiled from sub-categories as well as from open coding. As can be seen from figure 4.2 impacts of trauma can take many forms such as negative view of self, developing triggers to certain stimuli, and developing symptoms that may not have been present before the trauma or exacerbating previously held symptoms.

Negative self-view was described in many forms such as self-harming, self-hate, being a failure. An example of a statement from Participant seven illustrates the negative self-views held by many participants; "Not looking in the mirror and hating what I see." The yoga instructor also

described negative self-view but described it as a narration that people use throughout their day "thinking that you're terrible."

One of the group facilitators highlighted the feeling of being numb as:

> Sometimes what they're trying to do is, when people come to this group, is they want to be numb because their relationship with their emotions is, well, it's kind of adversarial.

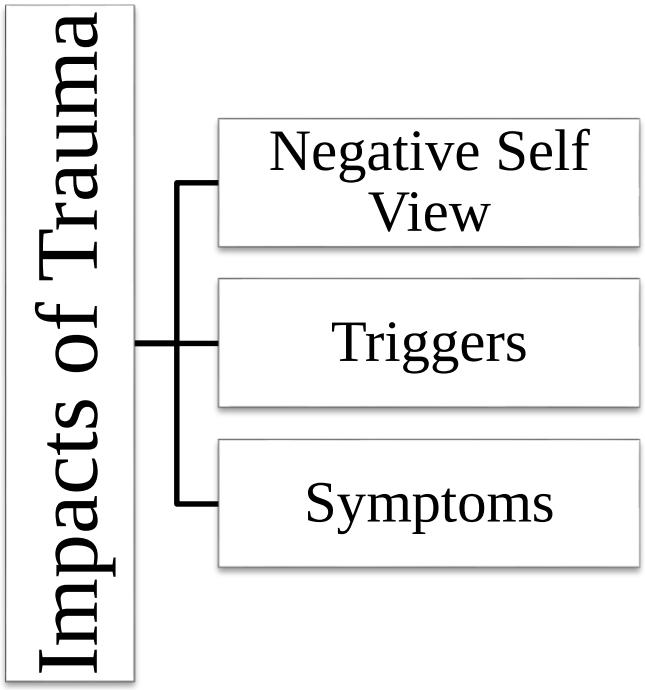
Participants also described the experience of being numb to their body and to their emotions such as participant eight describes:

> Well I know that personally for me I experience a lot of numbness and getting into my body and I know that's a common thing for people who experienced trauma and stuff like that so I don't really know anyone else who experiences that kind of thing.

In sum, group members, group facilitators, and the yoga instructor were all aware that individuals who have experienced trauma carry with them the lasting impacts of trauma. The impacts of trauma will emerge in any setting, daily living routines, as well as in survivors own thoughts.

Figure 4.2

Impacts of Trauma with Sub-Categories



Learn skills and techniques. The category of learning skills and techniques emerged from group member's wanting tangible skills to help alleviate and manage the impacts of trauma that they struggle with. The group facilitators as well as the yoga instructor also hoped to impart skills to group members so that they had the skills to gain independence and control over the impacts of trauma in their lives. In figure 4.3 examples of skills and techniques are shown, many participants did not have examples to provide they just knew they were looking for "tools" and a space to "practice coping skills" while the group facilitators and yoga instructor were able to label the types of skills and techniques they believed would be useful to the group participants to manage the impacts of trauma in their lives.

Participant seemed unsure of what the exact skills would be helpful to them but were aware of the need to have skills to help them manage trauma symptoms such as participant two stated:

> Coping to me, I think there are ineffective attempts at coping that are detrimental or not effective and not bringing me to a healthy place where you can work and solve your problem.

Illustrating an awareness of unhealthy coping and a need for coping but not exactly knowing how to get to a place of being able to work through and solve their own problems. One group facilitator provided this hope for group members:

> There's going to be some component that naturally gets their anxiety to spike, and it's in those moments for them to apply the skills so that they can get that experience of, 'okay, I can be aware of this and I can manage it and I can regulate myself.' Now that they can start doing that, they don't have to try to go through life never feeling anxious again or never feeling dysregulated or distressed again. That actually frees them up to start living more of a life that they may actually want.

Highlighted in the quote is the fact that the impacts of trauma will not be gone but the hope that participants will gain the autonomy to self- regulate so they do not have to live a life dictated by their trauma but instead can live how they want to. As the yoga instructor framed the aspect of gaining skills and techniques:

> You're going to get overwhelmed and yeah, you're going to cry throughout your life. Pain doesn't go away, but just to have a set of tools and knowing that you did it to be able to meet the adversity that come in your life with that.

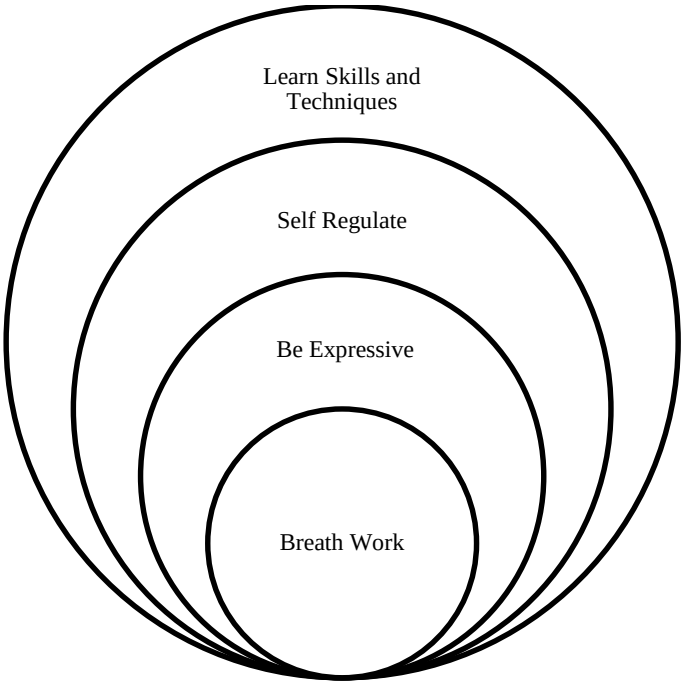
The skills presented by the group facilitators and the yoga instructor focused on being expressive about one's emotions, becoming aware of when the body is having a trauma response and is wanting to fight, flight or freeze. When gaining awareness of the body and the trauma responses there is a need to also be able to sit in those uncomfortable emotions and remind the

mind that the body is safe through body scans, grounding techniques of identifying what is in the room using the five body senses, utilizing EFT and breathing techniques.

In conclusion, participants were not required to have a PTSD diagnosis to participate in the group but many struggled with anxiety, hypervigilance, sleep issues, and dissociation from their body and emotions that emerged after their trauma. Participants all identified fairly quickly in interviews that they wanted and needed skills and techniques to manage the PTSD symptoms they had. All participants described an awareness that their current methods of coping were not working and a desire to have more out of life for some that meant getting back in touch with who they were before trauma, for others that meant becoming more than their trauma.

Figure 4.3

Learn Skills and Techniques with Sub-Categories



Experiencing connection with self and other survivors. The concept of the desire for connection emerged from group participant's as well as the group facilitators and yoga instructor interviews. The act of participating in group therapy was a new concept to every group member

so there was a focus of the "awkward" aspects of group as well as it being expected to be "uncomfortable" until group members developed a relationship. Even with the awareness that the beginning of group would cause personal discomfort all group participants echoed a strong need to understand themselves and to be around others who share a similar background of experiencing interpersonal trauma so that they did not feel so "alone" anymore. Participant seven stated:

> Sometimes I just don't want to burden people, other times I'm afraid they won't care or they will turn the conversation back around to themselves…when I open up I just want someone to say 'I hear you' not 'here's what you need to do'…I don't want people to fix me, I'm trying to do that myself.

The experiencing of others who have not experienced an interpersonal trauma not understanding or shutting down conversations related to mental health came up in numerous group member's interviews describing how the experience of surviving an interpersonal trauma can feel isolating. Participant eight illustrated a similar sentiment:

> Justifying my emotions, justifying the things I go through because I look at other people and they aren't going through the same things so it will be nice to see other people who are in my position, experiencing things as I am, struggling a bit as I am, so I hope to get out of it feeling less alone in the situations.

As participant five also shared a struggle with connecting to others:

> Finding some way to connect with people, I guess sometimes when you have something that happened in your life for me it gets hard. I can talk to you, quick conversation, on the surface but whenever things get deeper and I have a relationship, sometimes I struggle with that part so what I am looking for is like help with that part.

Participant five discussed a struggle of others potentially not being safe and how interpersonal trauma survivors may have had a deep trusting, connection with their perpetrator and now in trauma recovery connecting with others does not feel safe. A group facilitator also described wanting participants to learn about connection, as stated below:

> Safe connection is learning what connection is first of all. What are the different components of it, and what does unhealthy or a not safe connection look like, so talking about different power differentials, talking about manipulation is a big one that they've been through. Because these are people that have been through some sort of interpersonal trauma or violence or abuse, that means that sometimes connection to them means that connection is dangerous or connection is supposed to be hurtful. That's going to have a big impact on the kind of relationships they get into and can lead to being re-victimized. What this group hopefully gives them is a glimpse into that there can be such a thing as a safe connection, that is a real possibility, and for them to get an experience of that in the group.

The concept of wanting to understand oneself also was apparent as participant 3 shared "just being comfortable with myself, which I have struggled with before." As participant 2 shared:

> It's like learning to become human. I type that all the time they didn't give you a guidebook or manual so I think I am hoping to come out with a better sense of self and maybe a little bit of a guidebook.

The aspect of losing one's identity or feeling a lack of understanding about oneself after experiencing an interpersonal trauma and being unsure of how to reclaim it emerged in all interviews conducted.

The findings of wanting to experience connection with themselves and other survivors is new to the literature since trauma groups focus on PTSD symptoms reduction.

Figure 4.4

Experiencing Connection with Self and Other Survivors with Sub- Categories

Move forward. The category of moving forward emerged in terms group participants used about "moving on" and with the group facilitators as well as yoga instructor discussing how participants are being challenged in group but are learning how they are able to do difficult things that may be anxiety provoking and have it turn out alright. As participant one stated what she viewed the experience of participating in the group to be like "…to move forward, to go forward, not focusing on past experiences. Trying to find ways to go forward through all those experiences. Learning techniques to move forward." As the yoga instructor put it "they're doubting themselves. They're scared to do it but they did it anyways. Then look at it. Look at what you did. It turned out great. At least, not bad I hope." As one group facilitator stated:

> Maybe they feel empowered enough that they can take a chance and face uncertainty of getting a job across the country or going to a graduate program that's not in this area. They feel like they can face the distress of facing all the uncertainty and the questions that come from that.

Participants were unsure of what moving forward actually looked like for them since it had been some time since they had lived without their traumas. For some it meant being more social or regaining emotions they felt like they had lost the ability to feel. As participant eight stated:

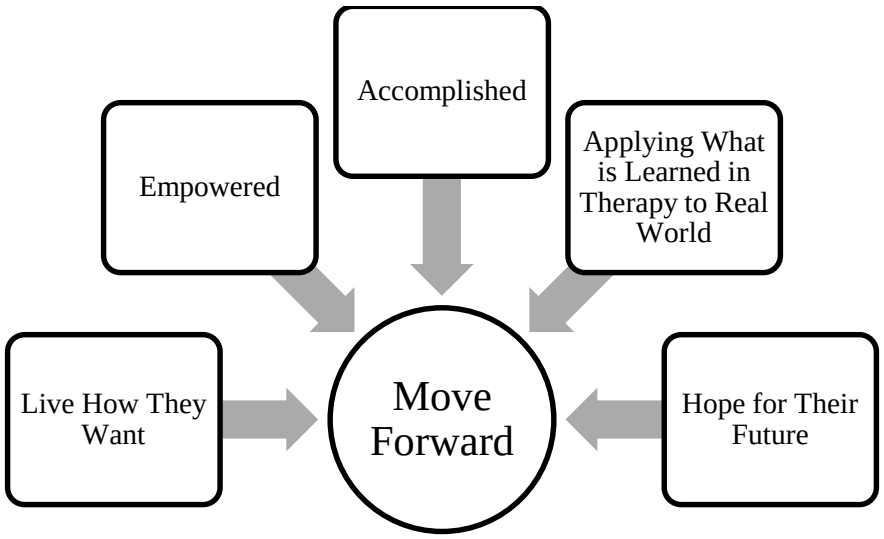
> I imagine I'll be more like myself I guess, definitely going through this process I've taken steps back from who I really am and I think talking to people and stuff like that I'm going to be more active in life and kind of have a foresight of the future, which I don't really have right now.

While participants three's focus was on regaining emotions as well as skills to regulate her emotions to help her move forward as stated; "I guess just being able to feel that emotion and get it out however that would be and moving past it, not harboring on it, kind of feel it, let it out and then move on."

In sum, moving forward from an aspect of their trauma was identified in each participants interview. Some members believed getting back to who they once were would help them move forward while others believed that decreasing their PTSD symptoms would help them move forward in life. As the yoga instructor and group facilitator each spoke to a decrease of judgment towards self and feeling confident, capable enough to get out of their comfort zone and try something intimidating. The group members, group facilitators, and the yoga instructor identified the components of group members bringing in their own impacts of trauma, needing to learn skills and techniques, and experiencing connection with self and other survivors to move forward in their lives so that they are no longer defined by their trauma.

Figure 4.5

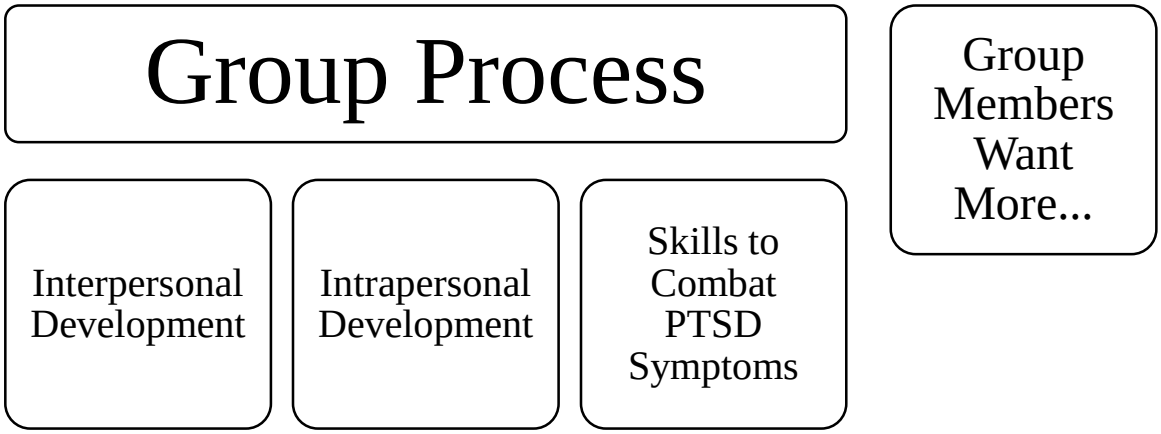
Moving Forward with Sub-Categories



In sum, the group members have all experienced the impacts of trauma and identified feeling alone and disconnected from others and themselves. Group members were able to participate in a group process that assisted them with interpersonal, intrapersonal development, skills to combat PTSD symptoms and group members were vocal about things they wanted to see more of in future Reconnection groups.

Figure 4.6

Post-Group Case Themes



Group process. The category of group process can be viewed as an overarching concept that led to the emergence of the other categories. The group process was described by group participants, group facilitators and the yoga instructor in many different ways but with the same theme of these challenging aspects being necessary for the group therapy process. This was the first group therapy experience for all group members so they had no idea what to expect besides what they had seen portrayed in media about group therapy.

All group participants described the group process as being intimidating but then becoming comfortable in the group as time went on. As participant three stated:

> It was intimidating at first just coming in having to talk about my feelings with strangers and doing yoga in front of strangers was scary and intimidating but I think after probably the first ghostbuster (psychodrama) I kind of I guess realized how beneficial it was and being able to share those emotions and be so vulnerable with people who were complete strangers was impactful. In the end it was a positive experience.

Group facilitators worked to normalize the experience of group being anxiety provoking for members by utilizing humor and reflecting body language that had been seen with all group members. Such body language included, everyone looking like they want to run out of the room during the first group session.

Participant two discussed the impact of emotionally challenging activities in the group such as the psychodramas and the way she felt in control:

> I felt very involved in the process when I voluntarily agreed to participate in the activities like volunteering yourself for ghostbusters (psychodrama), it's the commitment behind it. You show yourself in the group that you are committed to it and then it just felt very health to do it in such a safe space with people who could guide you.

The above quote illustrates a trauma survivor regaining a sense of control in herself, her therapy process, and her life. Which, for many group members having a sense of control was a new experience and for them to be able to practice that control weekly in the group has helped them develop interpersonally and intrapersonally.

As a group facilitator described the group as being challenging and rewarding to facilitate. He stated what he found rewarding about the group is:

> To see their progress. Because at the beginning of the semester the mindfulness aspects, relaxation, self-regulation, emotion regulation, practicing empathy, all these things were challenging for them. By the end they were getting pretty good at it. They could notice, and were reporting, that they also were understanding how they were getting better and better at it, and what the payoff was to having those skills.

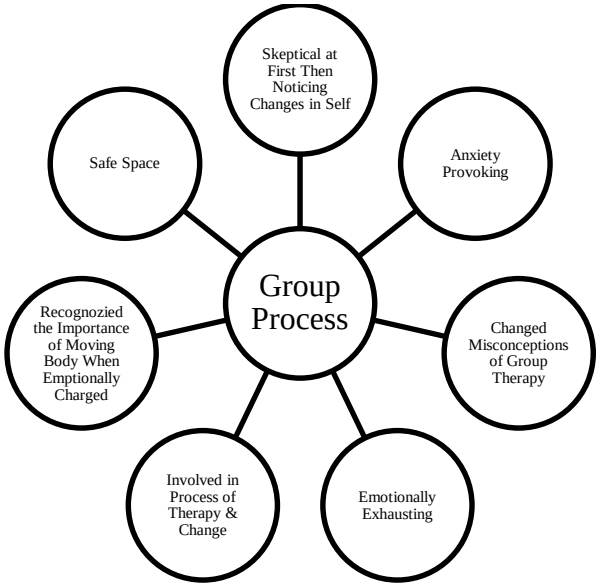
As the yoga instructor also highlighted "I could tell every client was trying. Not trying really hard physically to do the poses or flow but to get in the moment, to concentrate on what was happening to them as they experienced the yoga asana practice." Throughout the group process members noticed how group had gotten easier for them but the group facilitators and yoga instructor also noticed these changes as well in their mannerisms and communication.

In conclusion, the group experience was intimidating for all members at first but then as group progressed and members became vulnerable with one another they each felt like a safe community space had been developed where they were able to talk about anything without judgment. The process of group activities being challenging then getting easier with more

practice can be seen in the following examples. Through observation of the group it was very clear to see group members struggle with mindfulness activities for the first three sessions and then start to slowly get a grasp as to what worked or what did not work for them. This was observed through group member's frequent fidgeting and slightly opening their eyes through mindfulness activities to being able to sit still and appear comfortable being present. Group members became more comfortable and less fearful of their bodies and the practice of mindfulness activities that engaged their body awareness this was learned through group members self-report in interviews and processing discussions. Through observation and group member report during our second session when we discussed empathy many group members were surprised about the concept and had believed they knew what empathy was before but were shocked to learn that many were using sympathy instead of empathy. Participants slowly became more confident in their empathy skills and were able to provide empathetic responses to one another during our process time at the end of the psychodramas each session. Another example of participants gaining new information and skills and then by the end of the group discussing how much empathy has impacted them and how they use it in their daily lives now by describing how they communicate and connect with others outside the group.

Figure 4.7

Group Process with Sub-Categories



Interpersonal development. The concept of interpersonal development emerged in the pre-group interviews with group members wanting to connect with self and others but not believing they had the skills or ability to do so. In the post-group interviews the discussion of how the group provided a community, friendships, and a space to learn about healthy and safe relationships even if they did not have the same exact background or trauma they could still connect to one another.

I think the concept of being able to connect to each other even with differing traumas helped some group members see how they can apply this even outside of group to create connections with others who may not have experiences an interpersonal trauma. Relationships that may have become strained due to the impacts of interpersonal trauma, as participant three discussed:

> I've struggled with friendships here and it definitely got worse after my trauma so I think I built up these walls in all my relationships with my family and friends that kind of ending up ruining some relationships because I just didn't think that I could talk about it. Which, I kind of realized that I could or even share how I was

> feeling would have been more helpful so I am going to work on reconciling some of those if possible and just kind of not having that wall up because I've met new people so I am working in because you don't have to have your wall up all the time and I think vulnerability can be rewarding.

Group members were able to practice being vulnerable with one another and able to see what it was like to be vulnerable with safe people in a safe place instead of being manipulated by their vulnerabilities that some may have experienced by their perpetrators. Group members were also able to practice relational skills such as vulnerability, trust, boundaries, empathy and many more with individuals who had also become disconnected from these skills due to their interpersonal trauma. Participants wanted connection with others but did not think they had the skill or ability to connect with others. Participant seven described how group has:

> Showed me that I am capable of having that type of relationship and I haven't had that in a really long time and I kind of just thought I would never have it again. Just having a friend, having someone to talk to.

Being able to be in a safe group environment to practice interpersonal skills and develop friendships can be seen as inspiring and giving group members hope for their current and future relationships. Seeing aspects of themselves in one another throughout group gave group members more empathy for themselves and others. As one group facilitator stated:

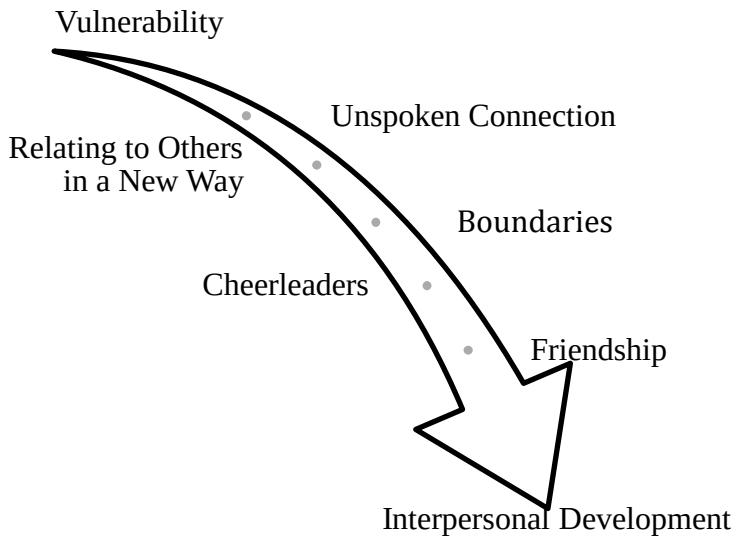
> I think they got a sense of community, a sense of connection just with each other. Some of them in group really liked chatting before and after groups, just about life and what was going on with them, and what was going well and what wasn't. I think that was really important. I think for some of them that was probably the first time they could really be vulnerable, and show what their struggles are, their imperfection, but still belong to a group. I think for some of them that was probably their first sense of, 'this is what belonging looks like,' rather than trying to fit in all the time, by trying to look or be perfect.

In sum, group members illustrated learning from one another by describing hearing parts of themselves in others psychodrama and feeling like they got a better understanding of themselves through observing others process but also being able to gain new insights through

their processing in group. The group members created a safe place for one another by practicing trust and vulnerability, which helped group members reframe how they view people. As participant two stated "it was really awesome to hear people cheer for me and then I guess I realized we were friends, which has been difficult for me to think people are trustworthy and care but it was nice." The group aided members in reconnecting with others to combat the shame and isolation that interpersonal trauma creates.

Figure 4.8

Interpersonal Development with Sub-Categories



Intrapersonal development. The category of intrapersonal development appeared in pre-group interviews with group members being aware that they had lost who they were from the impacts of trauma and wanted to regain connection to themselves. In the post-group interviews group members were able to identify their intrapersonal growth and development that they had experienced throughout the group therapy process such as gaining confidence, self-respect, and more intrapersonal skills. As participant six stated:

> Tools about cultivating self respect for myself was really big, self care learning about those things, learning about differences and that I can have my opinion and it's okay to not have to go out of my way to smile and not make everyone extremely happy all the time. I gained a lot of self-confidence too, definitely and that came from learning things about myself but also doing those ghostbusters (psychodrama) and stuff.

All group members described an internal process of change happening within them with some members expressing how their partners had noticed these changes as well and being surprised that it was transparent from an outside perspective. As stated by participant three:

> I've definitely seen changes within myself and being able to kind of see similar emotions in other people made me kind of also connect with my own emotions and like kind of pinpoint what I was actually feeling and that is something that I struggled with before. I asked my boyfriend if I changed at all since starting group and he said since my ghostbusters (psychodrama) I've let my guard down. It was good hearing that. I could feel the changes in my head but I didn't think it was enough for other people to notice.

Another aspect of intrapersonal growth that group members discussed was when they were apart of and observing others psychodramas the process of witnessing others gain new insights also provided clarity and healing to them. As stated by participant six:

> I felt like everybody was at a different stage in their healing and so through listening through that I felt like I heard myself through different parts and when they got healed I was having an aha moment with myself and healing that part of myself too.

Group facilitators also echoed the vicarious process by describing how building empathy for fellow group members also assisted participants in gaining empathy for themselves. As stated by one group facilitator:

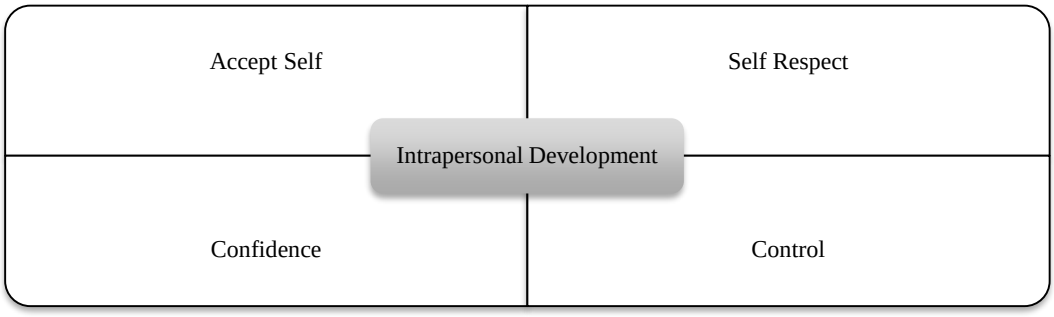
> I think they gained, one, a sense of normalization, that even though everyone in the group didn't quite have the exact same traumatic experience, the impact was pretty much the same. It kind of normalized that they themselves are not broken because when they heard other people's stories or experiences through the psychodrama, they noticed, I'm not seeing this person as someone who's broken

> and bad. That kind of empathy and understanding started to get directed towards themselves a little more.

In summation, group members were able to reconnect with themselves and learn how to have compassion and empathy for themselves by practicing it with others first. The group was a safe space that participants felt encouraged to work through stuck points in their lives through psychodramas as well as witnessing similar stuck points in others and vicariously gaining insights. Group members also built up their confidence and self-respect by trying things outside of their comfort zone during group such as psychodramas or even expressing differing opinions with other group members.

Figure 4.9

Intrapersonal Development with Sub-Categories



Skills to combat PTSD symptoms. Although it is not a requirement to have a diagnosis of PTSD to participate in the Reconnections group many of the members have developed some symptoms of PTSD since experiencing interpersonal trauma. All members expressed varying degrees of isolation from others, the world, and themselves. Also, members described how much control their thoughts had over them and how these negative thoughts increased anxiety and fears of not being safe. Participants also expressed experiencing dissociation from their feelings or specific feelings that they viewed as unsafe emotions and dissociation from their bodies. As participant one stated:

> I had told the group I learned how to feel, that in a way has backfired because now I apply it to everything in my life and I cry because I feel with you but I definitely learned how to feel for people and feel for different situation that before I didn't care about. I was very apathetic with everything. Through the group I've learned to relate to people on a different level.

The quote from participant one highlights how interpersonal trauma survivors can be dissociated from others and the world around them and how group gave them a space to regain connection to themselves and others. Being able to have connection can give interpersonal trauma survivors a better quality of relationships and life by integrating them back into the world instead of isolating from the world. As well as providing participants skills and ways to practice connecting with their bodies as participant three described:

> I had never done yoga in a group setting before so that was also scary at first. I was like 'I am not going to be good at this' even after the first day; I was like 'I'm not good at this, I'm not going to like this' but I think the first time I realized how important it was, was after my ghostbuster (psychodrama). I was so tense and I realized that stretching and moving really helped that. I felt tension in my legs, they must have been locked the whole time, I just felt exhausted. So I think that really helped me because if I would have left feeling like that then I would have just went and laid in bed forever. I kind of got over the 'people are going to judge me because I can't do this yoga move to it's okay' I kind of realized it's fine. I realized just connecting with my body like oh this feels good or this doesn't helped me.

Yoga was an important aspect of the Reconnection group to provide an outlet for participants to release emotional energy as well as a way to practice mindfulness and increase awareness of ones body. As the yoga instructor stated:

> They gained some understanding of autonomy with their body and even their thoughts, getting a taste of not completely identifying and believing all of their thoughts. They also very simply gained the understanding and practice of how powerful the breath can be in a time of discomfort. That the breath may not take the discomfort away, but it does give one back some of their autonomy, power if you will over the current emotional and physical state.

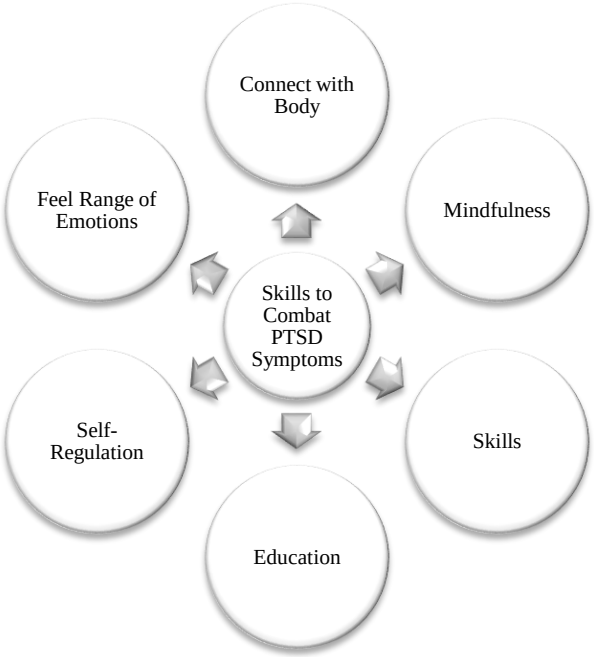
Yoga as well as skills practiced in the group supported participants working from being reactive to responsive to physical and emotional triggers. The development of being responsive provided participants with some time to respond how they want to. As stated by one group facilitator:

> The third thing I think they got out of it was skills, and how to apply mindfulness. How to apply self-regulation, emotion regulation skills, and different techniques that can help their body feel differently. Noticing how, when that happens, their emotions feel different, or not as intense at least, and they can respond rather than just constantly react.

In summary, skills learned throughout the group process time as well as the time spent in yoga assisted members in combatting their PTSD symptoms. Group members reported getting back in touch with their feelings, their bodies, building self-respect and confidence through their participation in the Reconnection group. In the pre-group interviews participants had identified a want for skills and techniques to combat PTSD symptoms but were unable to label what those skills would be. At the end of group members were able to identify what had changed for them and how they were managing PTSD symptoms more so than they had been able to prior to group as well as things that were emotionally triggering to them.

Figure 4.10

Skills to Combat PTSD Symptoms with Sub-Categories



Group members want more. Group members struggled with identifying aspects of the group that were least helpful to them but were able to easily identify what changes they would recommend. Participants were very vocal about how important they felt the group was as well as what they wanted more of in the Reconnection group. As participant two stated:

> I think it was imperative for me to have this type of group experience, I had been seeing Sam individually and couples since January and I don't think I recognized some of the insights I was able to have in couples. I just am so trapped within myself sometimes its very hard for me to get the picture, I read a lot but I just can't get the picture and put it into practice. I think this was the best thing I could have done, I wish I could do it again, I wish everyone could do it. I would think that something that lasted for 12 weeks would be great, even more sessions but I was very isolated and I didn't even know it and then this Reconnection group it took a while but I think it finally clicked why I needed reconnections and who I was reconnecting to. I don't think I am quite there yet but this has been great, I am so glad you are doing this.

Group members were invested and wanted the group to continue in the future so that other interpersonal trauma survivors could receive similar benefits that they themselves found in the group. As participant six stated:

> What I want to say is that I recommend anybody who is told about this group to join it's something that is much needed, it will help you in so many aspects of your life…I just really hope that you guys will keep doing it even though I am graduating and I won't be able to keep doing it I want to make sure that other people have access to it because I have gained so much from it.

Group members recognized how helpful it was to have a diverse group together for their own process of healing. The diversity of stages of healing, ethnicity, and gender helped them identify aspects of themselves through each other's psychodramas. Group members who had male perpetrators were able to practice safe and healthy male relationships with the male group member as well as develop empathy since males can be victims of interpersonal trauma too. As participant two described:

> I recommend wholeheartedly I don't think isolating the group into women's or men's, I really loved the group that we had…I think its important to me that people of color feel represented, but I don't know just diversity I would love to see diversity in the group ages too like we had. I was glad to have older group members.

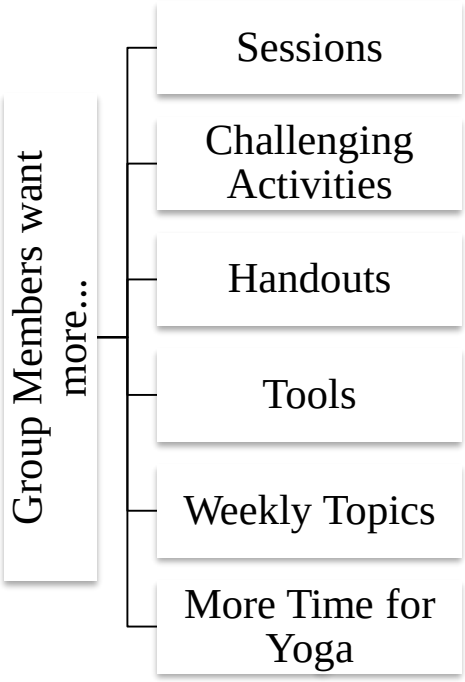
Group members also saw value in challenging group activities that had taken them out of their comfort zone. Members discussed how valuable it was for them to regain a sense of control by volunteering for challenging activities and also being pushed to new limits by group activities such as mindfulness and the psychodramas. As participant two stated:

> I want people to be pushed a little more because personally that's where I did the best, I really got a lot out of that and I think sometimes I guess you have to be ready for it, you have to be asked to be pushed…If there could be more try activities, I think it just feels so good when you do it and it comes out okay so more try activities.

In summary, participants, group facilitators, and the yoga instructor all identified a need for more sessions. None of the participants mentioned in their interviews or displayed during group sessions discomfort over the diversity in the group. In fact one member identified the diversity as helping her not view all men as perpetrators. Some members wanted more handouts and structure by providing weekly topics such as empathy, vulnerability, and forgiveness since they had gotten so much out of the session focused on empathy that they wanted more sessions that followed a similar format. All the feedback taken from group members in the past have helped develop the Reconnection group into the format it is today. The feedback from participants in the study will also be utilized to make adjustments to future Reconnection groups.

Figure 4.11

Group Members want more with Sub- Categories

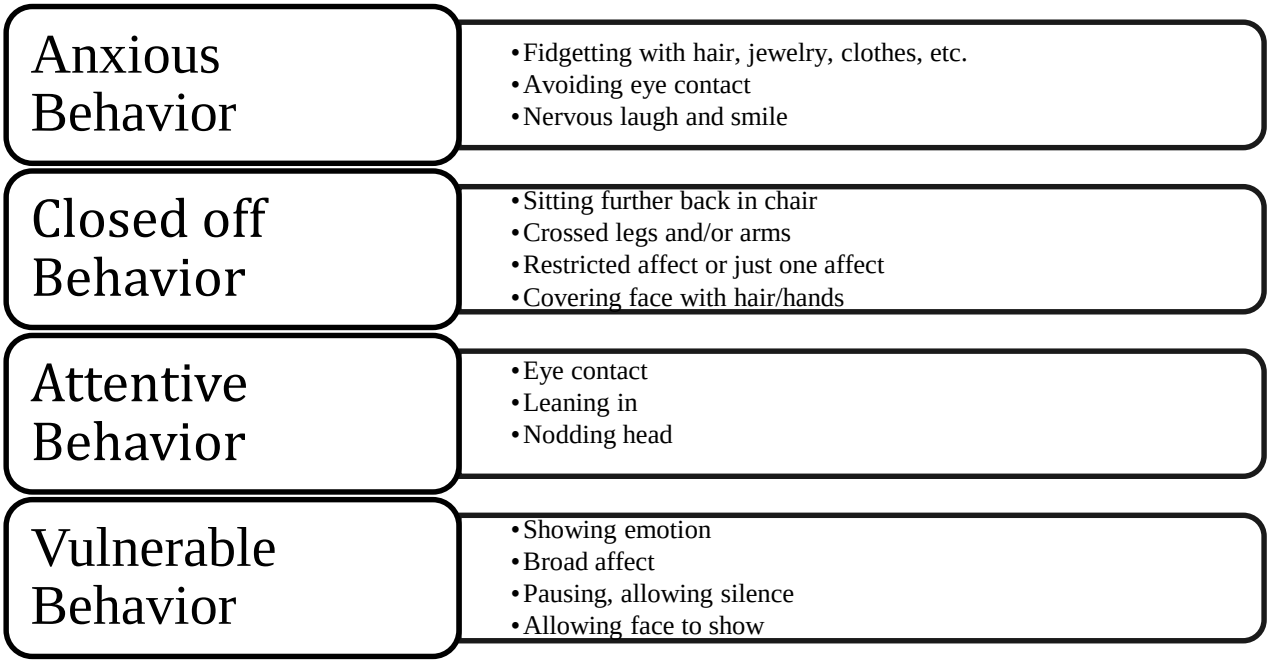


Body Language

Recorded interviews with participants prior to group and at the conclusion of group were utilized for transcription purposes and to observe changes in their body language that may have occurred. Many interpersonal trauma survivors do not feel safe or connected with their bodies so utilizing psychodrama and yoga in the group process which incorporates body awareness was believed to help participants gain a safe connection back with their body. The body language observed in pre and post interviews can be categorized as a. anxious, b. closed off, c. attentive, d. vulnerable behavior. The below figure illustrates the actions that were observed to create each category.

Figure 4.12

Body Language Category and Actions



Although many of the participant's body language remained the same from pre and post interviews, there was small adjustments in body language that can be noticed. Such as, the acknowledgement of emotion and affective change in participants, allowing their face to be shown and not covered by hair or hands. In the pre-group interviews all participants displayed anxious behaviors, as well as an affective response of nervous laughter and smiling. In post group interviews a few group members became tearful when discussing group ending and the healthy relationships they had during group and displayed a broad affect in the interviews instead of one affective response this change was most noticed in participant one and seven.

The most dramatic body language changes were seen in participant seven who struggled with many anxious and closed off behaviors in the pre group interview and for the majority of the Reconnection group. Some behaviors observed were holding her stomach with her arms folded in front of her, shaking legs, biting her lip, and hiding her face with her hair and hands.

By the last two sessions of the group and her post interview participant seven leaned forward with hands resting on her lap with her elbows rested on the armrest in an open posture with relaxed legs and allowing her face to be shown even in moments where her hair would start to fall onto her face she would readjust her hair behind her ear. This change is significant for participant seven since she self-reported during group and from observation as being highly distressed at all times. See below table for body language changes in participant seven.

Table 4.2

Participant Seven Body Language

Pre-Group Interview Body Language	**Post-Group Interview Body Language**
Crossed arms	Fidgeting with tissue
Holding body	Sitting forward
Face hidden by hair	Nodding head
Crossed ankles	Swinging legs
Anxious laugh	Smiling
Shaking legs	Chew on candy
Rub arms	Relaxed legs
Silence	Eye contact
Fidget with ring	Silence
Crack knuckles	Leaning in
Play with hair	Push hair away from face
Bite lip	Arms open & rested on arm rest
Rub face/ place hand on face	Scratch face

With other participants' body language changes did not occur. Participant three did display more assertive behavior by letting me know she wanted to talk about aspects of group that she did not think she had a chance to through the interview questions. This change of behavior for participant three was different than what had been observed during group. During the group participant three could be observed as having an affective and body language response to what was being said in group but would not speak up unless a group facilitator specifically

asked her thoughts. The responses she would have were reactive facial expressions, holding her body, or beginning to fidget in discomfort.

Although only minor changes of body language had been observed for most participants these changes could potentially be perceived as more significant to participants especially in the way that they are working to relate to the world around them.

Overall Case Conclusion

The findings of the study explored a unique aspect of group work by exploring interpersonal trauma survivor's experience of participating in a group that incorporated psychology and physiological approaches. Interpersonal trauma survivor's beliefs about entering into a therapy group has not been explored and is a gap that was found in the literature. The need for interpersonal and intrapersonal development to take place in the interpersonal trauma group was needed for survivors to identify themselves as progressing and gaining what they needed to move forward from their trauma experiences. Incorporating physiological engaging approaches such as psychodrama throughout the therapy process is another gap that was found in the literature since the majority of physiological approaches utilized with trauma survivors are used as an adjunctive treatment to talk therapy. While the Reconnection group utilizes psychodrama, which engages the body and mind as the talk therapy treatment.

Based on the research findings, interpersonal trauma survivors need a therapy approach that builds skills, engages them in doing their own intrapersonal work but also develops their interpersonal skills so that they can begin the process of feeling connected to themselves and others again to move forward so that their life is no longer defined by their trauma and dictated by their trauma symptoms. With this in mind it seems that to be able to create a space for intrapersonal growth as well as connection to oneself approaches need to focus on more than

engaging the mind but also the body so that an interpersonal trauma survivor can get back in touch with their body, emotions, and who they were before their trauma happened.

Although there was three members who dropped out of the group I think for those who continued in the group it did have an impact on their well-being. With the high number of drop outs in the group there is a greater need to do better screening in trauma related groups. Which literature supports this need since trauma related groups are known to have higher dropout rates.

Summary

The results of this case study were obtained from multiple data sources. To confirm the findings of the study participant interviews were compared against the group facilitators and the yoga instructor's interview for the categories found. By collecting interviews from three different sources as well as in group observations and body language observations from pre and post group interviews, I was able to establish data sources triangulation to support the study's findings.

Chapter Five: Discussion

Overview

The following chapter includes the purpose of the study, the research question, a comparison of categories identified in the study with those found in the literature, the limitations of the study, implications, and the recommendation for future research.

Purpose of the Study

The purpose of this qualitative explanatory case study is to understand the elements of a trauma group treatment modality that utilizes psychodrama as the primary treatment option and incorporates mindfulness and yoga as adjunctive treatments with individuals who have experienced interpersonal trauma that attend a public university in the Mid-South of the United States. Of specific interest is the physiological and psychological impact that this treatment modality will have on survivors of interpersonal trauma.

Research Questions

Through my research the following research questions will be explored:

1. How do interpersonal violence survivors and group facilitators describe the process and elements of a group therapy modality that incorporates psychological and physiological approaches?
    a. How do interpersonal violence survivors perceive a group therapy modality that incorporates psychological and physiological approaches?
    b. How do facilitators perceive a group therapy modality that incorporates psychological and physiological approaches?

Research Findings

The findings from the Reconnection group align with all but one domain of the theory of posttraumatic growth. The domains that align are; a. greater appreciation of life and changes in priorities, b. Improved relationships with others, c. Increased personal strength, and d. New possibilities in life (Tedeschi & Calhoun, 1996). The domain of posttraumatic growth that was not identified in the current research study is the change or discovery of spiritual development by participants. Tedeschi and Calhoun (2004) identify individual characteristics that can cultivate posttraumatic growth, they are a. personality traits, b. managing distressing emotions, and c. supporting and disclosure with others. In the Reconnection group participants identified an intrapersonal and interpersonal development as well as gaining skills and techniques to combat their PTSD symptoms, which aligns with the cultivation of posttraumatic growth.

Impacts of trauma. The literature as well as the current qualitative study highlight the impact trauma can have on one's life. As Miller-Graff, Howell, Martinez-Torteya, and Hunter (2015) express how examining psychological functioning and types of violence exposure can be particularly beneficial with the college population due to it being a common age for the onset of psychiatric disorders. Experiencing interpersonal trauma in childhood have been found to increase the complexity and severity of mental health problems (Cloitre, Stolbach, Herman, et al., 2009). Common trauma symptom complaints are focused on the inability to be present, calm, feeling in a fog, being overwhelmed with anger, and lacking meaningful engagement in their current lives (van der Kolk & Najavits, 2013). The group participants echoed this with their identification of struggling and being fearful in many situations that they may be unexpectedly trigged by a stimuli causing them to become panicked. Trauma symptoms continued to disrupt their ability to engage in a life that they viewed as fulfilling.

Learn skills and techniques. The finding in the pre-interviews with participant's wanting skills and techniques align with post interview feedback of participants identifying that they did gain skills to combat PTSD symptoms. In Herman's (1992) stages of trauma recovery she identified in phase one of treatment as needing to be focused on education to increase understanding of PTSD symptoms as well as teaching skills to manage stress and emotion before moving forward in trauma recovery. The literature also describes that skills and techniques such as mindfulness, nonjudgmental attention to the present have assisted interpersonal trauma survivors in emotion regulation (Bishop et al., 2004). Group members did struggle with mindfulness skills and had trouble tolerating unstructured mindfulness activities at first until they developed the skills further. Group members did seem to do better as well as ease into the concept of mindfulness when done with an instructor who guides them to continue focusing on bodily sensations while regulating arousal through breath. The struggle of participants was observed in the group and also discussed in interviews as well as noted in the literature as being a common theme among trauma survivors (van der Kolk et al., 2014).

Experiencing connection with self and other survivors. Reconnection Group members wanted to connect with others and themselves again but felt that their trauma symptoms served as a barrier keeping them from who they were, who they want to be and others. The group format assisted in connecting back to self and others due to the nature of being vulnerable with strangers and having empathy for strangers and in turn themselves. Keenan, Lumley and Schneider (2014) identify the group dynamic as being imperative to overcoming trauma symptoms such as numbing, emotional detachment, and for reconstructing connect back to self and others. The unique and powerful component of group therapy is the ability to create relationships with fellow group members to assist in normalizing experiences, feelings, receive support, and learn from

others who have had similar experiences (Yalom, 2005). As Keenan, Lumley, and Schneider (2014) found when group members are able to experience and express compassion to another group member with a similar story it can provide a new perspective and help in their own healing by mirroring forgiveness and empathy. This was observed and identified in interviews with group members at first having an easier time having empathy and compassion for other group members and once they discovered pieces of themselves in others story they were able to mirror that empathy and compassion to themselves.

Move forward. A theme of group members desire to move forward from trauma emerged with survivors not knowing how to get there on their own. Gulden and Jennings (2016) found that participants identified yoga as helping them "leave their trauma at the door" which suggests self-care routines such as yoga can assist in the concept of moving forward and not always feeling identified by a trauma experience. The literature on psychodrama supports the theme on moving forward by describing how the ability to role play oneself and re-enact aspects of a traumatic experience gives the client the ability to explore unexpressed emotions, say or do things they wish they could have; creating hope and transferring blame from the client to the perpetrator (Dayton, 2005). Through the exploration that is taking place in the client's role-play new perspectives and meanings may be made about the trauma experience (Dayton, 2005). This can be seen happening through the Reconnection group with client's identifying that they are not actually broken or damaged because they experienced interpersonal trauma. As well as client's identifying that past environments or relationships were unhealthy and did not provide them with what they needed but that did not mean they as a person were lacking.

Group process. In the findings of post group interviews there was a focus on the process of group this theme of group being difficult, having autonomy in decision-making, and group

being intimidating but it all turning out all right. The finding is new to the literature with current studies addressing group member's connection with one another but not noting any of the autonomy that was found in the current study or the impact of the trying intimidating tasks in a safe group environment. Previous literature does not address the group environment or the group process itself for interpersonal trauma survivors so this is a specific point of interest that can be grown in future research studies.

Interpersonal and intrapersonal development. A finding from interviews was the new found ability of Reconnection group participants to be able to connect with themselves and others again on a deeper level than they have ever been able to do. The findings align with previous literature that also found that yoga helped participants relate to themselves again and with this they reported they were able to create healthier, positive, and closer relationships with other (Gulden & Jennings, 2016). Interpersonal connection and development also aligns with the theory of posttraumatic growth identifying that healthier, closer relationships can be developed after adverse life events (Tedeschi & Calhoun, 2004).

Psychodrama techniques align with the finding of interpersonal development since group members are a part of each other's healing process with group members playing the role of auxiliary egos, which are members chosen by the protagonist to represent persons in the drama and acting as therapeutic agents for the protagonist and facilitating the enactment of the many facets of a protagonist's life (Kipper & Hundal, 2003). The roles portrayed by auxiliary egos is focused on what the protagonist wants to work on and not personal issues of other group members but auxiliaries may gain indirect insight from the portrayals of their roles (Kipper & Hundal, 2003). This was observed in the Reconnection group and accounted for in the post interviews with participants becoming emotionally moved by others stories as well as seeing

themselves in others stories. The experience of seeing themselves in others stories and having empathy for another's experience helped group members practice self-compassion since they did not see their fellow group members as broken or damaged; therefore, they are not either. Group members were also able to hear feedback about how strong, brave, etc they were once the psychodrama ended and time was spent processing the psychodrama. During the processing time group members were able to spend more time on interpersonal development by being vulnerable with one another about what came up for them during the psychodrama as well as asking fellow group member's if it was okay to hug them and provide comfort for them.

As Keenan, Lumley and Schneider (2014) describe their choice to utilize a group treatment method for combat veterans due to a group format creating connection and trust from sharing painful experiences with others who can relate. In the post interviews group members identified a realization that they had distanced themselves from potential supportive individuals after their interpersonal trauma, which was also described by Keenan, Lumley and Schneider's (2014) combat veterans that they had chosen to keep an emotional distance from important people in their lives out of fear of losing them. The power of connecting to others and sharing one's story so that they are not bearing it alone anymore isolated by shame that existed for the group members was a new experience for all of them that they were not expecting.

Previous research has found that those who practice yoga and mindfulness experience positive benefits such as self-acceptance, engagement in life, and interoceptive awareness (Follette, Palm & Pearson, 2006). An aspect that yoga helps to cultivate is self-acceptance, which may lead to self-love, hope and acceptance (Gulden & Jennings, 2016). Gulden and Jennings (2016) found that participants in their study reported being able to honor themselves, their bodies, and their emotional limits through the practice of yoga. To achieve self-acceptance

participants had to reduce judgment and increase compassion and respect for themselves and they reported an increase in confidence and sense of internal power to assist them in creating change (Gulden & Jennings, 2016). The findings from Gulden and Jennings (2016) align with what participants reported at the end of the Reconnection group being able to develop intrapersonally by practicing self-respect, having control in their life, confidence, secure in self, learning about self, and accepting self. Gulden and Jennings (2016) found a theme of love, empowerment, and acceptance of oneself from a consistent yoga practice assisting interpersonal trauma survivors in recovering from the effects of trauma. Yoga has been found to promote personal growth, health, and emotional wellbeing (Gulden & Jennings, 2016) which is consistent with Reconnection Group participant's self report of the things they gained from participating in the group.

Skills to combat PTSD symptoms. Consistent in literature exploring yoga in the treatment of trauma are the skills that assist participants in alleviating anxiety and trauma related symptoms. In a study by Gulden and Jennings (2016) participant's identified skills and techniques such as mindfulness, breath work, physical movement, yoga postures, and psychotherapy aiding in the decrease of their interpersonal trauma related distress. Yoga as well as guided mindfulness activities in the Reconnection group provided a space to practice developing breath work skills and presence. As Gulden and Jennings (2016) found combining yoga and psychotherapy assisted in multiple aspects of trauma recovery. Providing interpersonal trauma survivors with skills to rebuild their relationship back with themselves and their bodies can help them regain a sense of safety (Gulden & Jennings, 2016). Regaining safety can lead to feeling more in control for trauma survivors allowing a relationship with the body to be rebuilt (Gulden & Jennings, 2016).

Mindfulness used on its own and in the practice of yoga has been identified as assisting in emotion regulation instead of avoidance, which is common in PTSD symptoms (van der Kolk et al., 2014). Van der Kolk et al. (2014) found that the physical postures and introspective nature of yoga were identified as critical variables in decreasing PTSD symptoms. It is believed that participants practicing and tolerating physical sensations of yoga postures can use this tolerance to disconnect physical feelings from the emotional reactions caused by trauma reminders (van der Kolk et al., 2014).

Group members want more. Among the literature there is a lack in input from group participants illustrating that in trauma groups researched group participant's feedback and changes from feedback are not made. The fact that group members are asked to provide feedback on the group during the last group session is a unique aspect of the Reconnection group. Even more rare is the feedback being used the following semester to modify and adjust the Reconnection group to the college student's evolving and changing needs. The Reconnection group is a collaborative partnership with group participants having ownership of their trauma recovery, which can be seen in post group interviews by the participants. Research does support developing a collaborative relationship early on in the therapy process to have greater treatment outcomes (Horvath, Del Re, Fluckiger & Symonds, 2011) but a gap remains in receiving feedback from clients and adjusting the treatment as needed from their insights.

In the literature there are descriptions of institutions calling for an increase in research to find more treatment options for interpersonal trauma survivors, as well as needs for prevention programs. Miller-Graff, Howell, Martinez-Torteya, and Hunter (2015) identified how college counseling centers have adapted to meet the increased need for services by focusing on crisis management and short term services but ultimately not being adequate for students who have

serious psychopathology and trauma histories. The Reconnection group is a way to provide services to more students while doing therapeutic work that can alleviate trauma symptoms and potentially impact student retention rates.

Limitations

A limitation is my own possible bias since I have dual roles as the researcher and a co-facilitator of the group. This bias could also be present in interviews, data analysis and interpretation. The dual roles I had through the process can lead to participant response bias with participants potentially providing answers they believe I want to hear. During the fall semester it is more challenging to get participants for the group due to the demands for counseling services numbers being lower towards the beginning of the semester until students become aware of what services are offered on campus. Since the group and research was conducted on a college campus there are inherent stressors that students handle relating to their college experience such as exams, assignments, extracurricular activities, and part/full time jobs that at times effect participant's attendance to group. Also three participants did drop out so having a smaller sample size is a limitation as well as the fact that participants did drop out of the group. Another limitation for the research is the reliance on in person interviews. Something that was noticed is that interpersonal trauma survivors struggled with the in person interviews and this could be for a variety of reasons, the anxiety around a stranger or a recording device, questions being open ended and broad without participants having enough time to fully process the questions. Also some group members where currently in individual therapy and the group so the possibility of the individual therapy impacting what outcomes were observed and reported. Another limitation to note is the amount of interventions utilized in the group and not knowing which interventions are impacting what outcomes observed and reported.

Implications

With the increasing rise of individuals experiencing a trauma it can be expected for a clinician to work with a trauma survivor at some point in their career. The need for varying treatment options for survivors as well as holistic treatments to engage all aspects of a person in healing. This research demonstrates how interpersonal trauma survivors view the world after a trauma and how impactful a group experience can be for survivors to learn and develop safe, healthy relationships with one another. It is important that counselors have the training and can provide the most optimal treatment for interpersonal trauma survivors since trauma symptoms can be seen disrupting so many aspects of one's life. Counselors also need to be aware of the benefits a group can provide for interpersonal trauma survivors as a setting where a survivor is normalized, provided empathy, compassion, and vulnerability.

In counselor training programs it is important to teach theories and techniques that are new to the field so that future counselors can have a multitude of tools but also have the ability to be innovative. In interpersonal trauma treatment there is not a one size fits all intervention so it is important that future clinicians are learning a range of interventions. The research also highlights the unique experience interpersonal trauma survivors go through and there is a lack of training on interpersonal trauma survivors in counselor education programs with the primary focus being on in the moment crisis interventions.

Recommendations for Future Research

The college population is a common psychological research participant group with the most recent estimate being that 68% of psychological research is conducted using undergraduate students (Silk-Eglit et al., 2014). Surprisingly, with the high amount of psychological research involving the undergraduate population there is very limited research on interventions utilized

with interpersonal trauma survivors at the college level with the majority of research pertaining to military veterans. Universities have a high focus on retention and with 38% of students experiencing a traumatic event; the highest rates occurring from interpersonal trauma (CCMH, 2014) there is a high need to address the impacts of trauma with the college population. Furthering the research on trauma interventions to be utilized in a university setting that will benefit student retention and document retention rates could get buy in from university stakeholders on the importance of mental health resources on campus.

Veterans are the primary research participants in studies on trauma interventions but because of the unique needs of veterans, not all interventions are going to be as effective with the college population. Another aspect to keep in mind with the college population is the additional responsibilities and stress many students face in college such as working full or part time while being a student and potentially participating in extracurricular activities as well. Another unique aspect of the college population is that their perpetrator may be a caregiver or someone they lived with so moving away for college may be the first time they are safe and able to engage in any counseling services.

Another recommendation when doing qualitative research with interpersonal trauma survivors is that it may be more beneficial to conduct interviews through email to gain more insight since the participant can have time to sit with and process questions as well as provide answers they are happy with that they feel most accurately portray their experience. This is recommended due to group participant's feedback of the interview and interview questions being challenging especially when they felt in the spotlight. When participants reviewed their interviews many would describe wishing they had articulated their thoughts better in the

interview but they all felt like they were able to get out what they meant just not in the most concise or straightforward way.

Conclusion

In conclusion, the Reconnection group is a valuable addition to services offered on a college campus because of the ability to reach more students and to assist in the trauma recovery process that would be difficult to achieve in individual therapy, which is connection and integration with others and society. Along with findings in the literature that support mental distress such as PTSD can impact retention rates on a college campus, another area that the Reconnection group can help with is integrating students back into a university setting. Although retention rates within the group have not been researched that is an area for future research. It is also important to note the gaps in the literature that were found such as interpersonal trauma survivor's perception of entering into a trauma focused group, the group environment and process that is beneficial to trauma recovery, and trauma groups receiving feedback from group participants and utilizing the feedback so that they are collaborators in their recovery process.

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Appendix A

Informed Consent

Investigators:	Compliance Contact Person:
Megan Little, M.Ed., LAC, Principal Investigator	Ro Windwalker, CIP
Kristen Higgins, Ph.D., Faculty Advisor	IRB Coordinator
University of Arkansas	Office of Research Compliance
The College of Education and Health Professions	irb@uark.edu (479)575-2208
Graduate Education Building Fayetteville, AR. 72701	109 MLKG Building Fayetteville, AR. 72701

Description: You are invited to participate in a research study on the Reconnection Group offered through CAPS led by two licensed counselors. The purpose of the study is to gain a greater understanding of the effectiveness of the group. To gather your perspective you will participate in two thirty- sixty minute interviews prior to counseling treatment and at the end of the ten-twelve week group. The group will consist of 8-12 other members with group members continuing to be enrolled into the group until the first group session.

What to Expect in Group: The first hour of group will begin with a mindfulness exercise then spent processing how past traumas are effecting members in the present such as struggling with anxiety, connecting to others, sleeping, etc. Members will have an opportunity to volunteer to process through conflicts that have happened due to their traumas. The last hour of group will be spent doing yoga together as a group with a certified yoga instructor.

Risks and Benefits: A component of the group is mild physiological exercise in the form of yoga, which could cause physiological discomfort. You will be reminded in every session that everyone has different physiological limits and that you can stop at any time during the poses. The benefits of yoga include reconnecting with your body, become more attuned to yourself, improve emotion regulation skills, and increase wellness behavior. During one group session a 5-minute demonstrations of massage will be offered this is voluntary the risk can be discomfort and triggering emotions stored in the body. The benefit of the massage can be becoming more attuned to your body and releasing built up tension. The risks in a therapy group are the potential discomfort over topics covered and the limits of confidentiality when participating in a group. To minimize the risks participants will all be currently in or completed individual counseling to assist in processing through difficult topics that may arise in group and the limits of confidentiality in a group setting will be discussed in depth during the first group session. The benefits for you include having a safe community for you to discuss current struggles with others who may be going through or already have gone through similar situations, and it may help you resolve some struggles you are currently facing.

Voluntary Participation: Your participation in the research is completely voluntary. There is no form of payment for participating.

Confidentiality: All interviews will be secured and passcode protected. Only the researcher will have access to the data. Participants will be assigned an identification number during transcribing of data to maintain anonymity of participants. Information collected will be kept confidential to the extent allowed by law and University policy.

Right to Withdraw: You are free to refuse to participate in the research and to withdraw from this study at any time. Your decision to withdraw will bring no negative consequences to you.

Informed Consent: I, _____
have read the description, including the purpose of the study, the procedures to be used, the potential risks, the confidentiality, as well as the option to withdraw from the study at any time. The investigator has explained each of these items to me. The investigator answered all of my questions regarding the study and I believe I understand what is involved. My signature below indicates that I freely agree to participate in this study and that I have received a copy of this agreement from the investigator.

_____ _____

Signature Date

Informed Consent

Investigators:	Compliance Contact Person:
Megan Little, M.Ed., LAC, Principal Investigator	Ro Windwalker, CIP
Kristen Higgins, Ph.D., Faculty Advisor	IRB Coordinator
University of Arkansas	Office of Research Compliance
The College of Education and Health Professions	irb@uark.edu (479)575-2208
Graduate Education Building Fayetteville, AR. 72701	109 MLKG Building Fayetteville, AR. 72701

Description: You are invited to participate in a research study on the Reconnection Group offered through CAPS led by two licensed counselors. The purpose of the study is to gain a greater understanding of the effectiveness of the group. To gather your perspective you will participate in two thirty- sixty minute interviews prior to counseling treatment and at the end of the ten-twelve week group.

Risks and Benefits: As group facilitators/ yoga instructor the risk of the interviews are discussing and reflecting on topics that may be sensitive in nature. To minimize the risk group facilitators/yoga instructor will be aware that they can stop the interview at any time they need to. The benefits for you include sharing knowledge of how you view the group. Sharing this knowledge will broaden research of psychological and physiological group approaches for interpersonal trauma survivors.

Voluntary Participation: Your participation in the research is completely voluntary. There is no form of payment for participating.

Confidentiality: All interviews will be secured and passcode protected. Only the researcher will have access to the data. Participants will be assigned an identification number during transcribing of data to maintain anonymity of participants. Information collected will be kept confidential to the extent allowed by law and University policy.

Right to Withdraw: You are free to refuse to participate in the research and to withdraw from this study at any time. Your decision to withdraw will bring no negative consequences to you.

Informed Consent: I, _____ have read the description, including the purpose of the study, the procedures to be used, the potential risks, the confidentiality, as well as the option to withdraw from the study at any time. The investigator has explained each of these items to me. The investigator answered all of my questions regarding the study and I believe I understand what is involved. My signature below indicates that I freely agree to participate in this study and that I have received a copy of this agreement from the investigator.

_____ _____

Signature Date

Appendix B

UNIVERSITY OF ARKANSAS

Office of Research Compliance
Institutional Review Board

September 21, 2016

MEMORANDUM

TO:	Megan Little Kristen Higgins
FROM:	Ro Windwalker IRB Coordinator
RE:	New Protocol Approval
IRB Protocol #:	16-09-065
Protocol Title:	*Reconnection Group for Individuals Who Have Experienced Interpersonal Trauma: An Explanatory Case Study*
Review Type:	☐ EXEMPT ☒ EXPEDITED ☐ FULL IRB
Approved Project Period:	Start Date: 09/20/2016 Expiration Date: 09/14/2017

Your protocol has been approved by the IRB. Protocols are approved for a maximum period of one year. If you wish to continue the project past the approved project period (see above), you must submit a request, using the form *Continuing Review for IRB Approved Projects*, prior to the expiration date. This form is available from the IRB Coordinator or on the Research Compliance website (https://vpred.uark.edu/units/rscp/index.php). As a courtesy, you will be sent a reminder two months in advance of that date. However, failure to receive a reminder does not negate your obligation to make the request in sufficient time for review and approval. Federal regulations prohibit retroactive approval of continuation. Failure to receive approval to continue the project prior to the expiration date will result in Termination of the protocol approval. The IRB Coordinator can give you guidance on submission times.

This protocol has been approved for 30 participants. If you wish to make *any* modifications in the approved protocol, including enrolling more than this number, you must seek approval *prior to* implementing those changes. All modifications should be requested in writing (email is acceptable) and must provide sufficient detail to assess the impact of the change.

If you have questions or need any assistance from the IRB, please contact me at 109 MLKG Building, 5-2208, or irb@uark.edu.

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Appendix C

Pre-group questions to ask participants:

1. What do you want the experience of participating in the group to be like?
2. What do you hope to gain from participating in the group?

Pre-group questions to ask facilitators:

1. What do you want the experiences of clients participating in the group to be like?
2. What do you hope they will gain from participating in the group?

Appendix D

Post-group questions to ask participants:

1. What was the experience of participating in the group like for you?
2. What, if anything, did you gain from participating in the group?
3. What were the most helpful aspects of the group?
4. What were the least helpful aspects of the group?
5. What changes would you recommend?
6. Is there anything else you would like to discuss about your experience of participating in the group?

Post-group interview questions for facilitators:

1. What was the experience of facilitating the group like for you?
2. What, if anything, do you think clients gained from participating in the group?
3. What were the most helpful aspects of the group?
4. What were the least helpful aspects of the group?
5. What changes would you recommend?
6. Is there anything else you would like to discuss about your experience of facilitating the group and your observations clients' experiences?